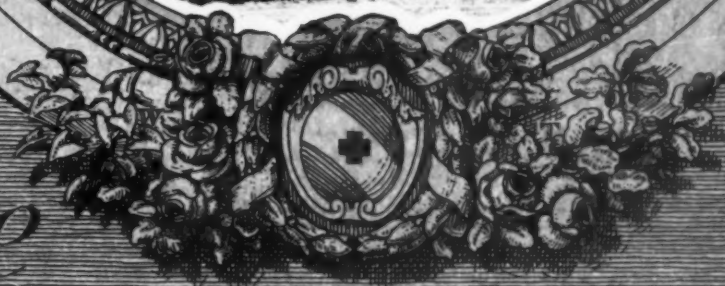


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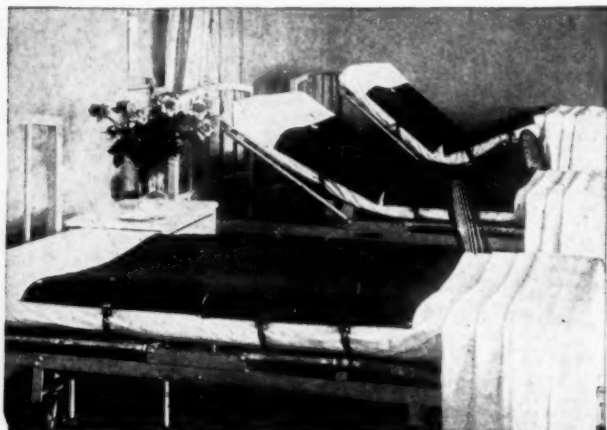
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THE MODERN HOSPITAL

A Monthly Journal Devoted to the Building, Equipment and Administration of Hospitals, Sanatoriums and Allied Institutions, and to Their Medical, Surgical and Nursing Services

Vol. XXVII

September 1926

No. 3

WHAT WE OWE THE MENTAL PATIENT

By Irving J. Sands, M.D., Associate in Neurology, Columbia University,
New York

THE modern hospital is expected to be fully equipped and manned to treat every conceivable ailment. The x-ray outfit, the bronchoscope, the electrocardiograph and other similar instruments of precision are expected to be a part of every modern institution. The prenatal, the nutrition and the cardiac clinics, though recent additions, are now well established in every progressive institution, and are practically on the same plane as the ordinary medical and surgical clinic of former years.

Any person suffering from any physical disease, no matter how acute or chronic, may safely apply to the modern hospital and receive proper care and attention. Yet the patient suffering from a mental disease frequently fails to receive help from the modern hospital. To the average medical practitioner, who does not recognize the true nature of the ailment, the mental patient is an enigma. In the medical schools, until recently, the courses dealing with mental disease were

usually limited to a few lectures given by a man connected with a state institution, and supplemented, possibly, by a visit to a neighboring state hospital. Moreover, the average medical practitioner has neither the time nor the inclination

to devote to these mental cases, and frequently he is unacquainted with the methods for dealing with such patients.

The average general hospital has no facilities to observe and treat mental patients, and the presence of such patients is generally a source of annoyance from the administrative, and trouble from the medical viewpoint. Consequently, the average superintendent of the general hospital is reluctant to respond to the ever increasing demand for the facilities for care of mental patients in a general hospital.

Discovery Through Clinics

DURING the past few years we have begun to consider that the problem of the treatment of mental as well as physical disease rests with the general hospital. If we are to do justice to the care of mental illness it is up to the general hospital to open its doors to the mild mental cases of the community.

In addition, as Dr. Sands has concisely outlined, it is the general hospital's duty to hold clinics and to provide adequate facilities and training psychiatrists to carry on this work.

The subject of the mental clinic in general hospitals will be handled by Dr. Sylvester R. Leahy, director of the mental clinic, St. Vincent's Hospital, New York, in our October issue.

During the past decade has come a marked change in the attitude not only of the medical profession but also of lay people regarding the treatment of mental disease. In the first place,

the War has produced a hoard of so-called "shell-shock" cases and has opened the eyes of the world to the importance of this problem, bringing it directly to the homes of many who had previously been unwilling to face it squarely.

In the second place, there has lately arisen a universal solicitude for child welfare. Charitable organizations, mental hygiene societies, teachers and parents have begun to realize that the adult of today is but the child of yesterday, and in order to produce a wholesome normal adult, the child must receive proper care and guidance. Then again, there has arisen a group of workers in the field of criminology who, despite strong opposition on the part of uninformed and misguided influential people, have persisted in hammering home the fact that delinquency and criminality are, in a large measure, the result of mental ill health, and of poor and inadequate mental training.

Science Dispels Mystery

Last, but not least, modern science has dispelled the halo of mystery that has surrounded the entire subject of mental life and mental disease, and has produced definite facts and principles that make human conduct and its disorders intelligible and amenable to change.

The modern hospital no longer can afford to stand apart from this progressive movement of understanding human behavior and remedying its aberrations. Prominent charitable organizations, child caring agencies, juvenile courts and even business and industrial organizations have found it both imperative and expedient to establish mental clinics for the care of the human beings who come under their supervision. The public is now clamoring for the general hospital to assume an active part in this movement, and hospitals at present can actively participate in this field of human endeavor and are in a position to assume the reins of leadership.

In discussing the subject more intelligently, it would be opportune to deal with it under three divisions: the scope of activity of the mental clinic; the personnel of the mental clinic, and the physical equipment.

In general, it may be stated that the scope of activity of this clinic should comprise the care of all who need skilled psychiatric care and guidance and who do not require commitment to a state institution. The mental defectives, especially those of the high-grade moron type, could be supervised in this clinic and be given adequate industrial instruction, and thus made self-supporting. These patients are a source of trouble to the school authorities, and in later life contribute in larger numbers to the dependents and delin-

quents of the community. If their mental defect is detected early, and if they are taught simple vocations and are given remunerative work, and taught to respect authority, they may become self-supporting and, furthermore, may be prevented from entering on delinquent careers.

The neurotic child should receive especial attention in this clinic, since when taken in hand early, such children lend themselves to proper adjustment and management. The home situation must be carefully studied, the attitude of the parents must be carefully observed and the inherent neurotic traits of the child must be analyzed in order properly to readjust the child's life. All somatic disorders must be combatted, and eye-strain, fatigue, malnutrition, anemia and irritating foci about the genitals must be treated. Night terrors, enuresis, and bad sexual habits must be corrected. Those children displaying bad temper, day dreaming, poor attention, or undue timidity and shyness, marked phobias, pathological lying or stealing, marked psychomotor restlessness and abnormal sex activity should receive intensive study.

As a matter of fact, the clinic may deal even with the preschool children, who, because of their plasticity, suggestibility, imitateness and love of approbation are very susceptible to proper training. Hence by teaching proper habits to the preschool child one may be able to prevent the formation of vicious habit reactions and insure a normal mental life in the individual.

Adolescent Needs Guidance

The adolescent child should also receive proper guidance. Emotional conflicts that arise at this period of life may be the basis for subsequent anti-social behavior, and the development of the sex urge at this period of life and the rigid inflexible rules laid down by society frequently cause conflicts in the adolescent that may cause mental disease. The clinic may do well to guide these youngsters through this delicate stage of development.

Psychoneurotics must receive especial attention in this clinic, for it is the neglect of this group of cases that is responsible for the growth of the various quacks and cults of healers. A proper understanding of the psychological mechanisms determining the behavior of the psychoneurotic and a sympathetic attitude toward the problem will enable the trained psychiatrist to teach the psychoneurotic to face the realities of life squarely and to lead a happier existence.

This clinic may also become a clearing house for problem children in the schools and for the wards of the various charitable organizations.

Likewise, the juvenile courts may be encouraged to send their delinquents to the clinic for study. Mild psychoses, such as symptomatic depression and dementia præcox cases that do not require commitment and the psychotic patients who are on parole from the state institutions may receive treatment here.

The clinic may also serve as a source of information on general psychiatric subjects for the medical profession at large. Owing to the various legal and sociological implications in dealing with mentally ill people, it is often necessary to have easily accessible data relative to social service agencies, charitable organizations, psychopathic hospitals, and state institutions, all of which can be furnished by these clinics. Because of its close affiliations with the other clinics, the psychiatric dispensary may be utilized as a teaching center where all types of mental diseases can be demonstrated to those physicians who do not otherwise have the opportunity to study mental diseases. Neurosyphilitic cases should be treated, for it is the trained neuropsychiatrist who is best fit to detect the earliest possible mental changes resulting from syphilitic disease.

The problem of delinquency and criminality at large could receive careful study, as it has been conclusively proved that there is a definite causal relationship between mental ill health and anti-social conduct. The sooner the legislators and civil authorities recognize this fact, the sooner will we be able more adequately to deal with these problems.

Trained Psychiatrist in Charge

Regarding the personnel of the clinic, one cannot too strongly impress the fact that it is important to have a thoroughly trained psychiatrist in charge, for the psychiatric clinic is to psychiatry what the operating room is to surgery. It is the operating room where the most skilled surgeons are to be found and it should be thus with the psychiatric clinic. The success or failure of the clinic will depend solely upon the ability of the psychiatrist in charge. Not only must he know psychiatry, but he must also know neurology, and must have had a good general medical education and experience. The psychiatrist in charge of the clinic can observe, study and treat those cases of mental disease that may complicate general somatic disease, such as psychotic episodes occurring in puerperium, pneumonia and typhoid fever.

A properly trained psychiatric social service worker is indispensable to the proper management of the clinic, for it is the social service worker who must get a complete history of the case and later adjust the patient to his environment. A

trained psychologist is also necessary for the clinic, since it is the psychologist who must make the various psychometric measurements and detect special aptitudes or disabilities in the patient. It is also important to have a trained secretary to keep adequate records.

The clinic must be adequately equipped to insure efficiency and thoroughness. The rooms should be arranged to provide privacy for consultation with the patient. There must be available the ordinary psychometric scales, such as the Terman revision of the Binet scale and the Pintner Patterson performance scale. There must be provisions made for serological study of the spinal fluids and for other biological tests. It is also highly desirable to have a small ward of a few beds set aside in the hospital for the purpose of studying those ambulatory cases that require intensive physical, serological and psychiatric observation, and for those cases of somatic diseases that may develop mental disorder such as occasionally occur in toxemias, puerperium, cardiac disease and arteriosclerosis. Wherever possible, it is advisable to have suitable provisions made for vocational education and physiotherapy.

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In ancient Greece, after the organization of the various schools of medicine, when the art of healing the sick was no longer a monopoly of the priesthood, if a patient considered the fee charged for a physician's services exorbitant, he was at liberty to apply to a tribunal instituted by the government for the purpose of settling questions of charge. The doctor was forced to accept whatever fee this tribunal considered fair and just, and when two or more appeals were made against the same physician, he was cast into prison as a felon and was forbidden ever after to practice medicine.

SIMPLIFIED HOSPITAL HARDWARE

By Charles F. Neergaard, Hospital Consultant,
New York

THE article on "Silent Control for the Patient's Door" in the April issue of THE MODERN HOSPITAL described hardware devised to meet a long felt need. The study of hospital hardware generally involved the consideration of what it was expected to do and resulted in "Hospital Doors and Doorways" in the July issue. This indicated that standardization in doors, trim and hardware would save a great deal of money. The present paper outlines a plan for simplifying hospital hardware, for reducing the selling expense, simplifying the hardware schedule itself, and setting up standard units composed of the best articles for each purpose, selected for their adaptability, long wear and freedom from constant adjustment.

The study that has been made seems to warrant the following conclusions:

1. That the present method of selecting hardware imposes an excessive burden of time and money, which may be largely eliminated.
- 2 That hospitals are spending more money than is necessary for finished hardware.
3. That they frequently fail to select the hardware best suited to their requirements.

A job analysis is always worth while if the job is big enough. The hospital field has a present building program of over three hundred million dollars, which will require from three to four million dollars worth of hardware. This would seem to warrant consideration of the subject.

Usual Purchasing Procedure

How is hardware usually bought? The procedure follows an old trade custom, one of the many ruts in which we thoughtlessly travel, which imposes a high tariff on the cost of every new building, and which seemingly has no justification save habit. The architect, building committee, hospital superintendent and contractor spend many valuable hours in the hardware showroom selecting from the hundreds of samples on display in the wide variety of items needed for the hospital, such as locks, latches, knobs, hinges and checks. Little effort is made, in most instances, to avoid the hardware blunders or to profit from the successful innovations in other institutions.

The hardware man then draws up from the architect's plan, a schedule listing all kinds and sizes of doors, windows and transoms, applying

to each from the selection made the various articles needed. This schedule, together with the detailed specifications describing each item, will cover from forty to fifty closely typed pages for a hundred bed hospital. When completed and the process usually takes several weeks, it must be consolidated, checked back, priced and submitted with the bid to the architect and builder. As a rule it is rechecked in their offices to catch possible errors. The architect usually makes a hardware allowance based on his judgment of what an appropriate selection for the building should cost.

Bid Often Exceeds Allowance

Not infrequently the bid exceeds this allowance and this necessitates a review of the entire subject. One session in the hardware sample room is generally enough for the building committee, and the revision is usually put up to the hardware man with instructions to "cut it down somehow" and he does. All of this cumbersome procedure consumes many days of high salaried executives and salesmen and is repeated over and over again on every new project. What is most to the point, the money value of the time expended represents an item of overhead that materially increases the price of the hardware.

Owners usually insist on competitive bidding but in finished hardware the competition is more fancied than real. Any firm that contributes the time and patience for the laborious preparation of the schedule and specifications naturally has an inside track on the job. The labor involved in considering and comparing proposals from other firms generally militates against successful competition.

The question this paper seeks to raise is "why not do it right once and save all of this waste in time and money?"

The results all hospitals want when they equip a new building are almost invariably the same, that is, noiseless operation, simple action, minimum upkeep, good appearance and low cost. Standardized hospital hardware seems logical. Those who have been studying the subject believe it practical. The many architects, builders and superintendents consulted have welcomed it in principle. The problem has been to make it possible. For over a year a group of experienced and interested people have studied and labored to assemble a series of unit hardware sets that will best ac-

comply what is needed for each type of door and window, while meeting the five desiderata above noted.

Eliminating complications and saving money in hardware naturally and necessarily involves similar consideration for doors and the frames to which the locks and hinges fasten them. The previous article suggested four sizes and six types of doors that can be adapted to practically every hospital requirement. The schedules are as follows:

Sizes of Doors

Symbol

A—3' 10" wide, for bed and general truck traffic, (patients' rooms, operating and delivery rooms, main kitchens, storerooms, etc).

B—3' 1" wide, for wheel chair and truck traffic (doors to patients' toilets, utility rooms, diet kitchens and fire exits).

C—2' 8" wide, for offices, etc.

D—2' 4" wide, for small closets, etc.

All 7 feet in height.

Types of Doors

Symbol

1—The typical door, one or more panels, or flush

2—The glass panel door to admit light

3—The door with 8" glass square for visibility

4—Fireproof doors for stairs and elevator vestibules

5—French type doors for solariums, etc.

6—Ventilating doors, 1" shorter than the standard height

Standardizing Hardware Specifications

Analysis shows that hospital door hardware in purpose logically falls into three general groups, which have been designated:

Symbol

N—*Noiseless*, silent hardware used in patients' quarters

S—*Self-Closing* doors of various types

O—*Ordinary* hardware used outside the "quiet zone"

The series of unit sets worked out applies to each type of door, window, and transom needed in the hospital plan. Each article in the set was chosen primarily because it would do the work in the best way. Cost was secondary, yet many savings have been effected in the aggregate.

Determined by Group Selection

The hardware selection was determined by a group of hardware manufacturers who make it, architects who specify it, builders who install it, metal door and trim manufacturers who must provide the cutting and reinforcements for it and hospital executives who, in the last analysis, must live with it. It is inevitable that there will be differences of opinion as to details, but those who have given their time and thought to this plan feel that they have at least made a start in the right direction. Standards will encourage rather than hamper improvements and progress, as the attention of many hospital people will be focused on a

limited number of articles, which experience and criticism will tend to better. The last word is always unspoken.

Each unit set, some twenty-five in all, is designated by a type symbol and number. These are marked on the plan with the symbols indicating the size and type of doors. This procedure enables the architect accurately to predetermine his hardware allowance; the hardware manufacturer to prepare his schedule in less hours than it now takes days; the door manufacturer to list and bid on a few standard sizes. The labor and expense for architect and manufacturer in preparing details and shop drawings will be cut to a minimum. No new or radical principle is advocated, as many architects have their own standard details and selections which, with slight modifications, they designate by symbols on each recurring plan. The suggestion that for hospitals the same standard details and selections be generally adopted merely takes one step farther.

Complications of Rural Sections

Over 40 per cent of the hospitals in the country have fifty beds or less. The pressing problem of hospitalization lies in the small town and the rural community. The local architect frequently is not familiar with hospital needs and practices. A consultant is not thought of; the building fund is limited. In such projects approved hospital standards will be of especial value. In assembling the hardware sets it has been the purpose to make them equally acceptable to the wealthy institution where cost is secondary and the small hospital where cost necessarily governs. One of the leading hardware manufacturers in the country is cooperating in this plan and now has on the press a catalogue describing in detail the proper set for each purpose.

What will the end results be in dollars and cents where the suggested standards are adopted? Take a specific hospital on which the figures are available—a 100 bed institution with separate nurses' home and service building, that has 428 door openings. The schedule and costs would be as follows:

		Wood			Metal	
		Unit Cost	Total Cost		Unit Cost	Total Cost
A	3' 10"	85 @	\$26.00	\$2,210	\$35	\$2,975
B	3' 1 "	129 @	20.00	2,580	32	4,128
C	2' 8 "	166 @	19.50	3,237	30	4,980
D	2' 4 "	48 @	18.50	888	29	1,392
			<hr/>			
			\$8.915			\$13,475

The door manufacturers who have considered the program have suggested that standardization would effect, conservatively, a saving of 10 per cent on wood doors, or \$891, and 20 per cent on

metal doors, or \$2,795. The buck manufacturer who, as outlined in a previous article, furnished fourteen different shaped bucks at costs ranging from \$9 to \$18 a unit, has stated that if all had used the simplest and most appropriate design, which incidentally cost \$9, he could have saved 20 per cent, making his average unit price \$7.20. The average cost of the fourteen different bucks was \$13.50, so there would be a saving in favor of the standard article of \$6.30 or, for the 428 door openings, \$2,696.

The hardware manufacturer estimates that his economies in production and selling costs, through the use of the standard unit sets and including the substitution of the less expensive noiseless patient's door hardware for that conventionally used in completely equipped hospitals, would be at least 30 per cent. The hardware contract for a 100 bed hospital is in the neighborhood of \$10,000, so that the saving would approximate \$3,000. Summarizing this the economy effected by standardization in this particular hospital would have been

Wood doors	\$ 891
Metal bucks	2,696
Hardware	3,000
	<hr/>
	\$6,587

This saving would have been sufficient to purchase all the sterilizers for the institution, or to equip the x-ray and laboratory departments, or completely and adequately to furnish twenty-five private rooms.

The simplification suggested would save not only money but the time of all concerned in the building operation. It would speed construction, and ensure to each institution which used it the best possible selection so far as group judgment can provide it.

HOW THE NEW YORK LAW WILL AFFECT STATE HOSPITALS

The new law for the administration of the state hospitals and schools in New York groups them both in a single department called the Department of Mental Hygiene under a commissioner. The method of committing patients to the institutions will also be unified and every doctor who is qualified as an examiner for the insane can also make examinations for mental deficiency and certify to their need of commitment to a school. Physicians will no longer be in doubt regarding who has jurisdiction over a case, for the same commissioner will handle all cases growing out of mental abnormalities.

Commenting on the new law, the *New York Journal of Medicine*, says:

"The program for the care of the mentally sick would be entirely inadequate if it embraced only the fully developed cases. The great hope of stemming the rising tide of insanity and mental defects consists in prevention

while the abnormalities are in a preventable or curable stage.

"The state has maintained a system of clinics for several years, but has not provided the personnel for carrying on the clinics in a proper manner. The burden of conducting the clinics has fallen on the hospital staffs who already are overworked with the care of the patients who are in the hospitals. Yet the system has been demonstrated to be a great success. Over one-fifth of the cases in the Utica State Hospital enter the institution as voluntary cases as the result of advice given to them at the clinics. This might seem to indicate that the clinics are filling the hospitals with cases which might not need to go there. But, on the other hand, the cases go out practically cured after a short time. After the system is well under way with state-wide control, the great number of advanced cases will probably be much reduced, and there will be an end to the race of constructing new hospitals fast enough to take care of the increasing number of cases."

PROVIDING FOR THE PHYSICIANS OF THE COMMUNITY

The policies of administration of hospitals and their interrelationship with physicians of the community vary greatly throughout the country according to the character of the hospital and the community it serves. They are affected not only by the size and character of the community but by the relative proportion of free and private patients, by the kind of patients admitted, that is, whether it is a general or special hospital, and by the traditions of the place. There are, however, some fundamentals that should be recognized by both partners in this work, which are applicable in all of these varying conditions.

The hospital should try to meet the medical needs of the individual which cannot economically, conveniently or efficiently be met in the patient's home or the physician's office. This applies to the ambulatory as well as to the patient who requires bed accommodations.

From the standpoint of the physician, an ideal would be to provide facilities for all well qualified practitioners. This can be and is done in a good many of the smaller communities, but seems to be impossible in the larger cities. Patients in the hospital undoubtedly receive better care if there is an organized staff of limited size and with definite responsibilities. Experience has shown better results with a separation into distinct services, medical, surgical, laboratory, obstetrical and the other departments. Experience also shows better results if the responsibilities for each service are definitely placed on one individual. It is also wiser not to have these units too large, as there is a definite limit to the number of patients which one head can possibly supervise. We often see two or more separate services of the same kind in the larger hospitals. So in the more densely populated communities a given hospital can offer facilities to only a limited percentage of the physicians of the community. It should be the duty of that hospital, however, as far as its means permit, to make it possible for the members of its professional staff to fulfill their duties so conveniently and expeditiously that they may render the greatest amount of service with as little waste of time, effort and money, as possible.—*William Darrach, M.D., in the Boston Medical and Surgical Journal, June 17, 1926.*

Sutter Hospital, Sacramento, Calif., supplies its patients with a packet of stationery, envelopes, and a blotter for use in correspondence during their stay.

HOW NEW ZEALAND CONDUCTS ITS HOSPITALS

By Malcolm T. MacEachern, M.D., C.M., D.Sc., Associate Director, American College of Surgeons,
Director of Hospital Activities,
Chicago

IN MY recently completed tour of the hospitals of New Zealand and the States of Victoria and New South Wales, Australia, it was extremely valuable for me to study the working of a system of hospital operation that is unique and in some respects remarkably effective. My work with American and Canadian hospitals will profit by the opportunity afforded me of comparing results obtained under widely different methods. And I hope that I may say with entire modesty that I was able to assist hospital authorities of the Dominion of New Zealand with information concerning American hospital practice and with inspiration to adopt some of its notably good features. But the cementing of bonds between the countries visited and America, seeking in spheres remotely distant to perform a common service to humanity, was more significant than any practical gains resulting from my visit. It was the evidence of this community of aim that made my work in New Zealand so interesting and pleasurable.

This work in New Zealand was undertaken upon invitation of the New Zealand Branch of the British Medical Association and was performed with the acquiescence and approval of the Dominion Government. Both these bodies lent every assistance in their power. The department of health arranged an itinerary that made it possible for me to see all types of hospitals throughout the island. The exhaustive survey that this itinerary entailed gave me a feeling of complete familiarity with hospital problems confronting the people of New Zealand. The government, through Dr. Valentine, director general of health, most courteously provided me on my arrival with an account of the early history of the Dominion hospitals, an explanation of the parliamentary act under which they are now operated, and a state-

ment of the deficiencies and abuses of the practical administration of this law. This report of the government was of great value to me in interpretation of the system I had been invited to study.

One of the main points of interest in this system is a financial support guaranteed by the government assuring hospitalization for even the poorest citizen of the Dominion. This underlying idea is sound, though we in America cannot wholly subscribe to all the practices connected with the working out of the scheme in New Zealand.

The authorization for the hospital system is contained in the Act of 1909, which at present divides the Dominion into forty-five hospital districts and sets up one hospital and charitable aid board for each district. The board is composed of not less than eight and not more than twenty members chosen by the electors of the various contributory authorities in the hospital district. Such contributory authorities are borough councils, town boards, county councils and



Superintendents of the four large metropolitan hospitals of New Zealand. (Left to right) Dr. Alec R. Falconer, Dunedin Hospital, Dunedin; Dr. Walter Fox, Christchurch Hospital, Christchurch; Dr. D. M. Wilson, Wellington Hospital, Wellington; Dr. C. E. Maguire, Auckland Hospital, Auckland.

road boards, or a combination thereof.

The hospital board performs two functions. It is responsible (a) for the management of hospitals and outdoor medical and nursing service and (b) for the administration of charitable relief. In general it carries on duties according to the policy outlined by the department of health and through the following institutions: (1) Base hospital; (2) secondary hospitals—district or cottage; (3) special hospitals—maternity, infectious diseases, tuberculosis; (4) benevolent or old people's home; (5) annexes or wards for tuberculous patients, in curable and incurable stages; (6) mental wards for psychiatric or incipient mental patients.

A most important adjunct to the work of the board is the district nursing service, which the



Upper Sanatorium or third division, Cashmere Sanatorium, Christchurch, for chronic patients.

board also directs. For the most part these nurses are sent to the more remote districts, the back-blocks, where their services as nurses and midwives are much sought. In the cottages provided for the nurses is usually an extra room or two in which emergency cases can be treated until they can safely be forwarded to the secondary or base hospital of the district. These rooms for patients are often used for the care of maternity cases.



Coronation Hospital, or first division, Cashmere Sanatorium, Christchurch, for receiving and acutely ill patients.

All classes of hospitals within a district are administered by the hospital board of the district under the control of the department of health and under direction of the minister of health. The director general of health is the chief executive officer of the department. He is assisted, as regards hospitals, by the director of division of nursing, by the inspecting accountant, by the inspecting house manager and by technical inspectors (such as architectural, engineering, etc.) The department has considerable power with respect to the inspection of institutions, books and offices. The director general can also direct boards to erect institutions where he considers them necessary and he can make all requisite provision for the sick and needy. No capital expenditure exceeding two hundred fifty pounds can be undertaken by a board without ministerial approval. The department is opposed to lengthy loans for capital works and declines to approve loans for a longer period than twenty-one years. It prefers that boards raise their requirements by levy and subsidy or by one or two-year loans. So

far as possible the department acts in an advisory capacity only, exercising its prerogative of control only when grave abuses are intended.

The board derives the necessary revenue for maintenance of the hospital system from patients' voluntary contributions, levies on contributory local authorities and government subsidy on both levies and voluntary contributions. At the beginning of each fiscal year, a board makes an estimate of expenditures which must have the approval of the minister. It deducts from this sum all estimated revenue, such as patients' payments, voluntary contributions and subsidy thereon. It then levies upon the contributory local authorities for one half the deficit. The contributory local authorities may pay the levy out of ordinary revenue or they may strike a special rate. The remaining half of the deficit is taken care of by the government subsidy on the levy. The Amend-

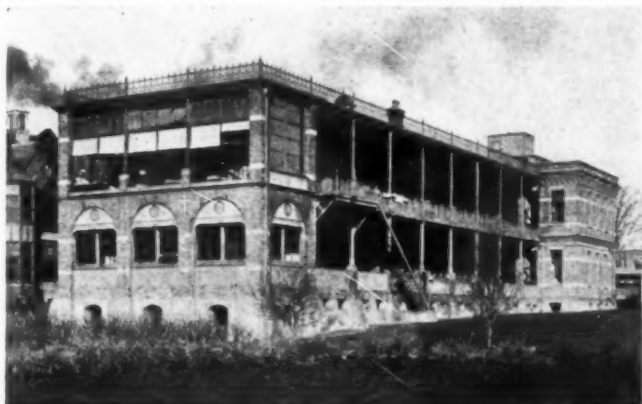
ment of 1923 grants these subsidies: 1 pound for every pound levied on contributory local authorities to meet capital expenditure; 1 pound (average scale) for every pound levied on contributory local authorities to meet expenditures other than capital expenditures; 1 pound for every pound of voluntary contributions. Every claim for subsidy must be accompanied by a statutory declaration, made by the chairman of the board, verifying a statement of all material particulars. The granting of subsidy is at the discretion of the minister, and this discretion is freely exercised in regard to voluntary contributions but has never been



Children's Preventorium, Cashmere Sanatorium, Christchurch.

used to curtail subsidy on levies on local authorities for maintenance purposes.

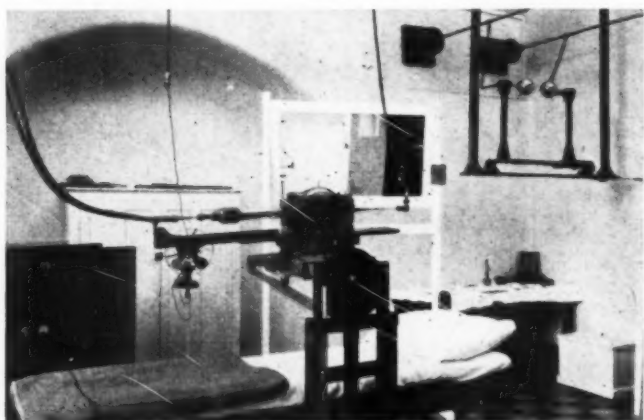
Along with its statement of the provisions of the act, the New Zealand government furnished me with a discussion of the limitations, the defects and the abuses of the national system of hospitals as administered under the act. A consideration of these handicaps and deficiencies and recommendations for overcoming the former and



Women's surgical and children's pavilion, Christchurch Hospital.

supplying the latter comprise the greater part of the report that I have made to the New Zealand branch of the British Medical Association and the Dominion Government. The report is also available to the hospital boards.

In this consideration one of the first points meriting attention is the effect of assured finance upon voluntary contributions. Hence I have urged



Deep therapy department, Christchurch Hospital.

an increase in voluntary effort and community interest through the following:

- (a) Systematic effort to secure gifts and benefactions in the way of
 - (1) dues of annual and life governors
 - (2) funds for special purposes
 - (3) endowments
- (b) Organization of women's auxiliaries, guilds, associations in each hospital district to supplement the work of the board of trustees



Administration building, Christchurch Hospital.

Another matter of vital importance is the composition of the board of trustees. The method of financing New Zealand hospitals through rates seems to necessitate election rather than nomination. The possibility of securing the services of the right kind of trustees is therefore dependent upon the education of the elector in regard to the proper membership of hospital boards.

A third change which seemed to be extremely important was that the chiefly supervisory capacity of the department of health be superseded by a controlling function exercised by some central, non-political board. This board should be composed of representatives of: (1) The government—the minister of health or the director general of health, as well as additional representatives if so desired; (2) the hospital boards; (3) the New Zealand Branch of the British Medical Association. The sphere of the existing Dominion Board of Health might be extended to include control of hospitals as well as health activities under a broader name such as the Dominion Board of Health and Hospitals. Its function with regard to hospitals should be: (a) The control of hospital policy, particularly as to the limitation of hospital districts; (b) the coördination of hospital districts, hospital boards and hospital activities of the Dominion; (c) standardization of hospitals.



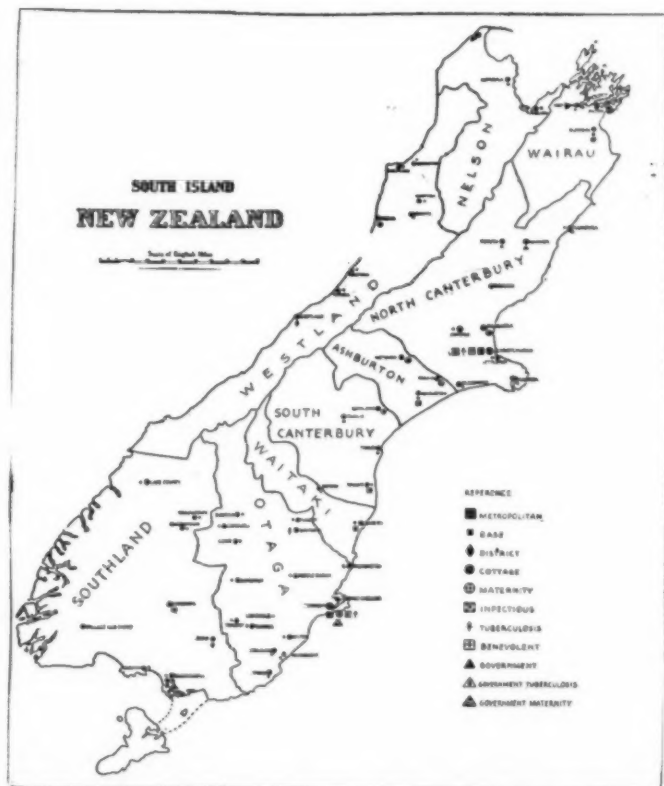
Corner of pathological laboratory, Christchurch Hospital.

should be separate wards for acute contagion and if practicable, for chronic and incurable patients. A maternity department should be under the same administration but, if possible, in a separate building. The secondary hospital need not have such extensive equipment for treatment but its diagnostic facilities should be adequate for all ordinary cases. That is, they should be sufficient for all routine laboratory tests and x-ray examinations. The work of the cottage hospitals should be chiefly that of caring for maternity and emergency cases until the latter can be sent to larger and better equipped institutions, if necessary. Special hospitals for communicable and chronic diseases should be provided as the needs of the district indicate.

Reducing the burden upon the ratepayer could be further effected by the addition of pay wards to all base and secondary hospitals. The rate now charged in the public hospitals does not cover half the cost of overhead and operation. Therefore the admission to the public hospital of any but the necessitous poor is an unjustifiable expense upon the ratepayer. The missing link in the hospital system of New Zealand is the lack of provision of paying wards with varying degrees of accommodation for persons able to pay. Another angle of this question of pay wards and one of even greater importance than the economic one is discussed under the suggested change of policy of



Map of North Island, New Zealand, indicating the different types of hospitals.



Map of South Island, New Zealand, indicating the various types of hospitals.

hospital staffing for the whole Dominion system.

The uneconomical administration of the present system is also clearly apparent in the practice of caring for chronic and incurable diseases in the general hospital. While patients of this type require more medical attention than they could receive in the cottage hospitals, they are not in need of the concentrated nursing and treatment which acute cases must have. Hence I have recommended that every district set-up include institutions for chronic and incurable patients.

A closer supervision of hospital activities is an imperative need. First, there should be competent constructive inspection of Dominion hospitals by an agent of the Dominion government. Such an official, who might bear the title of inspector general (or director) of hospitals, should be one who has had long and successful experience in all phases of hospital administration.

Second, the influence of local supervision would tend to bring about the standardization of the district set-up and to improve medical practice and hospital service in the community. The effectiveness of such local supervision would be greatly enhanced if systematic surveys could be made and to this end I have proposed that the superintendent of the metropolitan or base hospital in each district be assigned the duty of periodic in-



General view of Auckland Hospital, Auckland.

spection of all the hospitals in his district. He would make his report to the hospital board and thus the administrative and controlling phases of hospital activities would be brought into close and effective relationship.

Another recommendation I have made would add a third element of coöperative functioning. This recommendation looks to a more intimate union between the medical profession and the hospital boards. To further this union I have suggested: (1) The appointing of the honorary medical staff of the hospital of as many as possible of

pitals be abandoned. The custom of having medical director, matron and business manager in charge of respective departments but of equal rank and more or less independent of



Wallace wards, Auckland Hospital, Auckland, just completed.

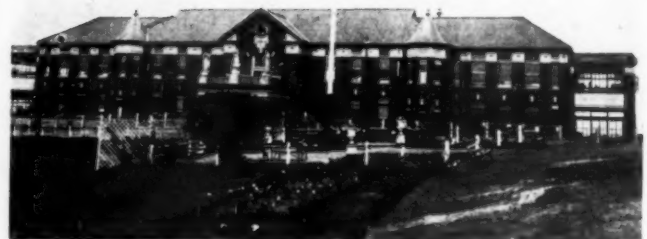
each other is not in accordance with sound administrative policy and is not productive of good results with regard either to finances or personnel, as it results in decentralized control.



Living room, nurses' home, New Plymouth Hospital, New Plymouth.

the doctors practicing in the community; (2) the seeking of the advice of the doctors in the community on professional matters and policies; (3) the holding of frequent round table conferences and joint meetings on problems of mutual concern; (4) the appointment of an advisory committee from the honorary medical staff to serve as a link between the latter and the hospital board.

In connection with the administrative and medical staffing of the hospitals, certain instances of prevailing practices which might lead to inefficient service were pointed out and recom-



Children's pavilion, Auckland Hospital.

Second, it was advocated that the method of constituting the medical staff be radically altered. The wholly stipendiary medical staff is not calculated to give the best service and should be replaced by an honorary staff organization which admits as many as possible of the practicing physicians of good repute in any district. These should be organized into special services in so far as practicable. They should care for the cases that are considered.



Nurses' home, New Plymouth Hospital, New Plymouth.



View of Cottage Hospital, Kaikoura. (Left to right) Isolation block; nurses' home; men's ward; women's ward; operating theatre; maternity block.

charity patients and be permitted to treat their private patients in the pay wards with no interference other than conformity to the regulations laid down for professional practice in the institution. This policy of non-interference should extend to the question of professional fees, a question which should remain a personal matter between the patient and his physician.

Such a staff organization as the one briefly sketched would result in much better care for medical cases, particularly those of acute infection, than is possible under the present system.

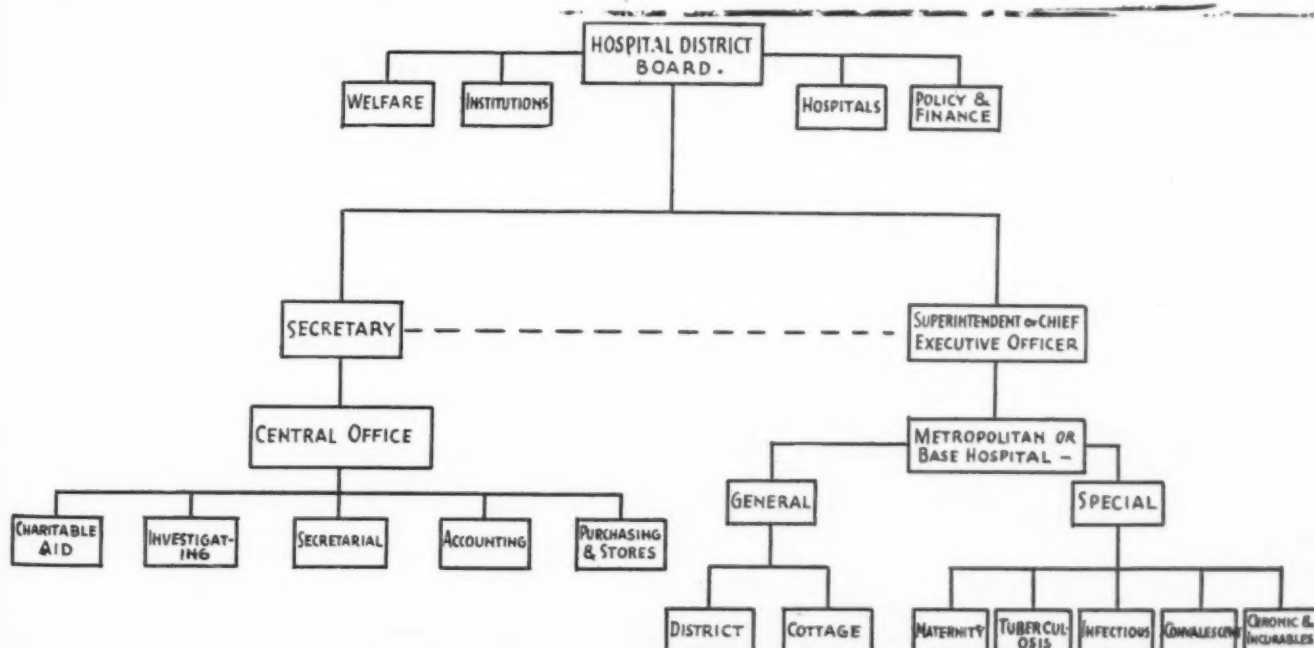
In connection with the medical practice within the hospital three other recommendations were made. These had reference to obstetrical practice, administration of anesthesia, and dietotherapy.

Most of the obstetrical work is performed by nurses and midwives, and the resident or medical officer in charge is called only in cases of abnormality or pathology. This system does not permit a resident medical officer to secure the necessary experience to enable him to become sufficiently skilled in obstetrical work before going into prac-

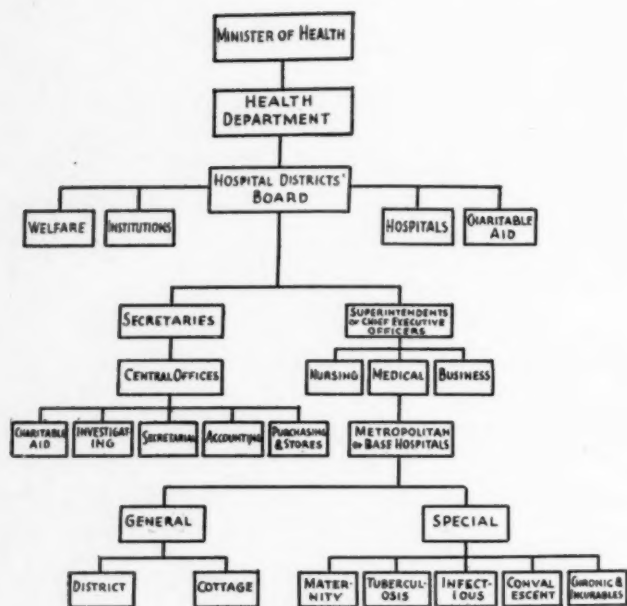
tice. In this respect I have urged that a member of the honorary medical staff, more or less specialized in this branch, be in attendance at delivery, even in perfectly normal cases, and that all resident physicians secure the necessary clinical experience under competent supervision. This would in no way interfere with the training of nurses and midwives as advocated under the present system and now a well established custom in the country.

It was found that anesthesia is frequently administered by untrained residents and often without the proper supervision. A discontinuance of this procedure was recommended and encouragement to several reputable physicians of each district to make anesthesia a specialty was suggested to obviate the dangers of the present practice.

The survey revealed that only one of the hospitals of the Dominion—the Dunedin—had the advantage of the services of a full-time dietitian. The importance to the internist of the aid of scientifically trained persons in charge of the dietary departments was pointed out and it was



General scheme of organization of hospital district.



Present scheme of organization of hospitals in the Dominion of New Zealand.

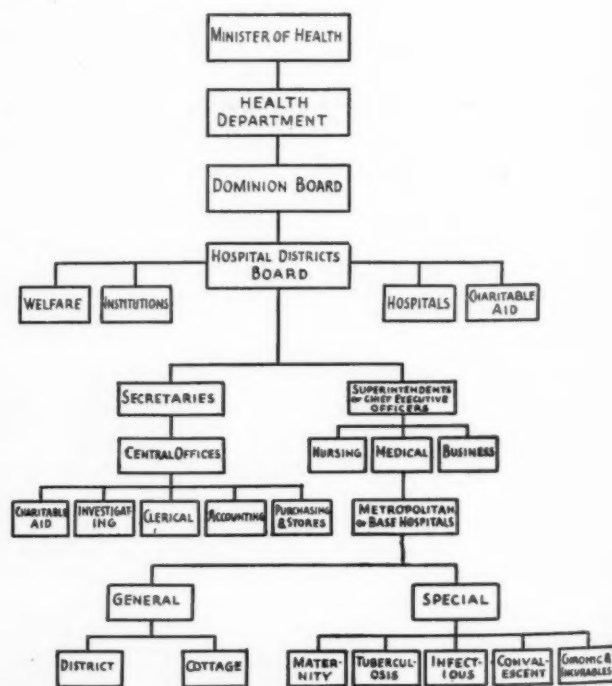
urged that at least all base and secondary hospitals adopt such a service at the earliest possible time.

Finally, I cannot conclude this fragmentary description of the hospital system of New Zealand without reference to the deep interest and fine constructive policies which have been worked out and recommended by the New Zealand Branch of the British Medical Association. The members of this organization are unanimously imbued with a desire to have the New Zealand hospital system hold a premier position, and they believe that through a consolidation of the three major interests, namely, the government—through the Minister and Department of Health and its officials, the Dominion Hospitals Board, and the medical profession themselves, a unique policy can be reconstructed giving due consideration to the worthy basic principles of the present system and the elimination of the weak points which have been found or the abuses which have crept in during the years under which the present act has been operating. In order better to consolidate the interests of these three groups I was fortunate in having a large meeting of their representatives, assembled at Wellington on April 7, a few days before completing my work. The numerous problems covered in my report, many of them arousing controversial opinions, were discussed at length and a more or less unanimous agreement reached and adjustments recommended. The two great problems facing the hospitals of the Dominion of New Zealand at present are: first—the re-establishment and further development of the honorary medical staff system to replace the present stipendiary staff; second—the

addition of pay and part-pay wards to the present public hospitals, in which the necessitous or poor shall get the same treatment and services as they now receive, and where there shall be accommodation for those who can pay part or full cost of maintenance and are privileged to have their own doctor, provided he is acceptable to the hospital management.

Boards Show Intelligent Interest

Nor can I pass without referring to the very intense and intelligent interest that the boards take in hospital affairs. This was clearly demonstrated at their two-day convention in Dunedin, which I was privileged to attend, and where representatives from all the hospital boards of the Dominion keenly and intelligently discussed the hospital problems of the Dominion. It was quite apparent that these representatives are actively interested in everything that pertains to the better care of the patient. I would also be very remiss if I did not mention the active and constructive interest that the minister of health, the health department and its officials, take in all phases of hospital development, organization, and administration. This was evidenced in their desire to secure all the information they could pertaining to hospital policies in vogue in other countries, in order that they might select the best therefrom to make such practical adjustments in their own system as are warranted. With a working together of the three groups mentioned above the future success of the hospital system of New Zealand is assured.



Suggested scheme of organization of hospitals in the Dominion of New Zealand.

IS THE NURSING SCHOOL KEEPING PACE WITH PUBLIC DEMANDS?*

By B. Henry Mason, M.D., Assistant Superintendent, Peter Bent Brigham Hospital,
Boston, Mass.

SINCE my graduation from medical school more than a decade and a half ago, marked changes have been witnessed in the nursing world. Standards have been changed and far more exacting demands are now made on the graduate nurse. Although general duty, administrative work, teaching and public health nursing are the four fundamental fields of activity for the graduate nurse, the scientific art of professional nursing is now viewed as such an essential factor in so many forms of human enterprise that new and attractive possibilities are presented to her.

The noble and efficient work done by nurses in the rapidly broadening field of public health nursing (in which about 11,000 nurses are now engaged) in visiting nursing, in public school nursing, in infant and child welfare work, in industrial nursing and in rural community nursing has attracted the attention of most public spirited individuals and lent an impetus to the movement to establish schools of nursing on a true educational basis. In order to meet the requirements and responsibilities of her chosen life work, the nurse must be a person of intelligence and good moral character, with an adequate preliminary education, a sympathetic personality, possessing tact, patience, and general nursing skill and ability.

The tendency of certain institutions, actuated by selfish motives, to offer, from time to time, short courses in nursing, is liable to attract the attention of uninformed and superficial observers. Graduates of such schools are, of necessity, deficient not only in the science and art of nursing

but also in professional ethics, and are thereby a cheapening element in the nursing profession.

The fact that some schools or hospitals offer a stipend to pupils should arouse in the minds of the prospective candidates a suspicion of the adequacy of the training given. Small and special hospitals that are not able to meet the minimum educational standard for schools of nursing should not attempt to conduct a school, and nursing care

for their patients can be provided by the employment of graduate nurses and nurses' helpers or attendants.

We must constantly bear in mind that the function of schools of nursing is to furnish the community with properly trained graduate nurses. The small training school that cannot offer something besides a simple technique that leads to the graduation of an automaton not actuated by knowledge of the true professional qualities of her service to mankind, should cease to function or to be recognized as a school.

We are not required to go far back into the

history of nursing, even in the United States, to form an opinion that young women of inferior educational advantages and attainment do not promote dignity or a serious consideration of one's obligation to stricken humanity.

We have heard much about the emancipation of woman from a degree of oppression since the World War. Whatever that may mean, I will not attempt to discuss, but we are cognizant of the fact, however, that the radical changes that have taken place during the process of adjustment since the signing of the armistice, have opened up many new and attractive fields of activity for young women of intelligence. In light of these facts, if young women of culture and

Apprenticeship or Education?

THE needs, possibilities and ideals of nursing education are all recognized by Dr. Mason in his comprehensive analysis of the nursing problem. He denounces the tendency of certain institutions to offer less than a three-year course and to lower the standards of nursing education by exploiting student nurses for the hospital's economic benefit, through the old apprenticeship method. He believes in the grading of schools and the creation of a minimum standard in order to bring about uniformity and place nursing schools on a sound educational basis. The opportunities for the large schools to develop through centralization and affiliation into schools that offer an adequate program of education in all types of nursing are fully realized by Dr. Mason.

*Read at the Fifth Annual Meeting of the New England Hospital Association, Hartford, Conn., May 21, 1926.

education, possessing high ideals and broad vision, able to view the social, economic, and political aspects of life from a true prospectus, are to be attracted to the field of nursing for a life work, schools of nursing must offer definite educational inducements.

It seems appropriate to mention just a word relative to the physical and mental welfare of the nurse during her period of hospital life. It is a known fact that the percentage of withdrawals of pupils from schools of nursing during training is larger than it should be, and the reason for this is not, in my opinion, due to lack of care in the selection of the candidates, but is largely the result of two conditions, both remedial to a great extent, namely, psychopathological condition, and environmental factors that influence the general morale.

Contacts Interfere with Duties

The same factors are operative with the pupil nurse as with the college student, but her daily contacts serve as a more active cause for the development of tensions and other reactions that interfere with the comfortable exercise of her daily duties and studies.

While I was engaged in neuropsychiatric work, it was not an uncommon experience to have a student from the school of nursing or college referred to me for consultation, with the information that her work had fallen below her general average, that she showed less interest or appeared nervous and could not apply herself. The failure of the pupil properly to adapt herself to school life is often due to tensions and neurotic states that result from unpleasant social situations in her home, or possibly to unfortunate personal experiences. If every maladjusted pupil, so-called "misfit," could be seen by a competent neuropsychiatrist, a large percentage would be salvaged from human wreckage to help swell the army of useful citizens.

Good health and any factors that may contribute toward a sense of well-being, help to maintain a high standard of morale in the school. I think it is safe to assume that the members of the entering class of all schools of nursing are given a careful physical examination by an internist and receive a dose of various vaccines to offer reasonable immunity to certain diseases. If there are schools that do not make this a practice, it would be of advantage for them to arrange to do so. Harmonious and attractive housing accommodations are prerequisite; pleasant dining quarters and intelligent dietary control are important; hours on duty should not be so long that the student will be in danger of taxing her physical and mental reserve strength, and there should be pro-

visions for the encouragement of social and recreational activities among the members of the school.

For several years there has been a marked tendency toward centralization and consolidation in an effort to increase efficiency and economy of operation. This movement appears to have taken on more momentum of late not only in the commercial world but in state and federal governmental affairs, institutions of learning and hospital administration. Although hospitals of varying size have sprung up rapidly all over the country during the past twenty-five years, I dare predict the future will witness a tendency toward consolidation and the development of the principal institutions, especially in our large centers, into larger units, rather than the building of new institutions. This should have a definite influence on the nursing problem.

In order to meet public demands, it has also been necessary to raise the standards in nearly all lines of human activity. This has been especially noticeable in the fields of educational and scientific development. The standards upon which our predecessor of fifty years ago looked with pride, are now obsolete and function only as inactive supports to the traditions of present-day institutions. If we, as individuals interested in the affairs of hospital administration and allied interests, are to do our part in promoting the intelligent and scientific care of the sick, we must divest ourselves of any remnant of selfish concepts and economic taint and view the problem in a fair, conscientious, altruistic manner.

Days of Apprenticeship Are Past

The days of apprenticeship for the nurse are, to a large degree, past, and it is evident that the tendency in this country is along the same evolutionary or progressive lines that have characterized the nursing profession since the establishment of the first school at the New England Hospital for Women and Children, in 1872, with a period of training of one year.

There are many branches or "specialties" (if you please) of nursing at the present time that require a higher quality of education than can be given in two and one-half or three-year courses as now required to give the nurse her basic training. These call for a broader training in the sciences and fundamentals in nursing that can be offered by a five-year course. Although it is probable that some hospitals would not care to relinquish the identity of a training school long established, it probably would be wise to have such schools of nursing on a definite educational basis with university or college direction.

The first two years of the course (the pre-hospital period) would be devoted to academic work during which the student would meet all her expenses, thereby relieving the hospital of the expense of furnishing maintenance for the pupil during her probationary or academic period. The second two years the pupil would be assigned to one of the hospitals participating in the course for her practical work, and the fifth year would be devoted to study and training in one or more specialties. An endowment for the school of nursing would be necessary to meet the financial burden necessary to establish and maintain such a department by an educational institution.

Some means should be found to standardize schools of nursing. If a minimum requirement were established, undoubtedly an effort would be made by all to meet it. This assumption is based on the example we have as the result of the establishment of a minimum standard for hospitals by the American College of Surgeons.

Grading of schools of nursing probably should not be carried so far as was done in the case of hospitals, nor can it properly come about through the length of the course. It appears that a sane basis for such a procedure would be determined by the content of the course and practical work and a correlation and evaluation of the two.

To secure and maintain desirable information relative to all schools of nursing and to be of assistance to the schools in meeting their educational problems, there should be one or more supervisors employed by the state board of registration of nurses.

The utmost care should be exercised to aid the general hospital in small communities to meet the minimum standards through the development of their own facilities for teaching and by arranging satisfactory affiliations with other schools.

State Hospital Schools Impractical

From several years experience in institutions for the care of psychiatric cases, I am firmly convinced that our state hospitals are not able to furnish adequate practical work and clinical material in the fundamental branches of medicine to warrant the maintenance of schools of nursing. In state institutions where an attempt is made to conduct a school, much difficulty is experienced in securing pupils even with a low-standard admission requirement. Most applicants are recruited through the medium of newspaper advertisements and are thus lured to the work by the remuneration offered rather than by real, active, altruistic motives. I have found that state hospital graduates are inclined to conceal the identity of their alma mater and to regret that they did not grad-

uate from a recognized school connected with a general hospital.

Pupils entering a school of high standing who are not constitutionally or temperamentally adapted to make successful nurses usually discover or demonstrate the fact during the first few months of school attendance, whereas the salary received by the state hospital pupil is very apt to arouse mercenary interest sufficient to induce her to remain a disinterested pupil and later to graduate a misfit or even a liability to the nursing profession.

I do not wish to convey the idea that I believe good, capable nurses are not graduated from a school connected with a state hospital, for many efficient, and even notable members of the nursing profession are alumnae of state hospital training schools.

Elevate Nursing in State Hospitals

Every effort should be made to elevate the nursing care and maintain it on a high plane in our state hospitals, but I do not believe the state hospital training school at present is an active factor toward such an end. If state hospitals would exercise the care in selecting female attendants that is now practiced in other hospitals and conduct a school for them for a period of a year that would embrace the fundamentals as are now taught, and arrange with recognized schools connected with general hospitals an affiliation whereby pupils who had received much of their basic training could receive a period of practical and clinical work in psychopathology and psychiatry (the length of the affiliation and the curriculum to be decided by mutual agreement) a great advance step would be taken to put state hospital nursing on a firmer basis. Should certain attendants desire to become nurses, they could enter a regular school of nursing, if their preliminary education would permit them to meet the entrance requirements.

There are those doing state hospital administrative work who will say that students from general hospitals do not well adapt themselves to psychiatric nursing. It is my contention, however, that if pupils from schools connected with general hospitals were assigned to duty on the infirmary and acute receiving wards under the direction of a capable head nurse, where they would have an opportunity to exercise the true art of nursing, they would not only adjust themselves to the environment, but would also demonstrate the superiority of the average nurse who has received her basic training in a school associated with a general hospital.

It would be desirable to have an eight-hour period of duty for such affiliating nurses, separate

rooming accommodations, separate dining room or at least, a section of the dining room reserved for such pupils. The physical arrangements of the wards, especially the infirmaries, and the equipment should be suitable to permit unlimited nursing care. The rapid turnover of female attendants, under present conditions in the state hospitals, many of whom enter without any knowledge of or experience in the care of the sick and leave before they have received much practical or theoretical training, is certainly not conducive to good nursing care and supervision. It behooves every healthy individual in the commonwealth, especially one in an administrative position, to do his part to foster some sort of cooperation between our well organized schools of nursing and the state hospitals. This would not only provide skillful nursing care for the acutely ill patients confined to our mental hospitals, but would give general hospital nurses valuable experience in the care of psychiatric patients. It is fair to assume that many having had such experience would choose neuropsychiatric nursing as their special field after graduation. It is unfortunate that selfishness or personal prejudice excite certain people to throw cogs in the wheels of progress. I am informed that only last year a person high in authority in the care of mental patients in one of the New England states issued an edict prohibiting lectures and clinics to students from general hospitals in the hospitals under state control for the care of mental cases.

Unaware of Demands and Responsibility

To summarize, I believe the public is to a large degree unconscious of the demands it is making of the nursing profession and is equally unaware of the responsibility it owes to nursing education and that which it should assume.

During the past decade marked changes in conditions have taken place in the community and our schools of nursing must adjust themselves to the new requirements. The profession of nursing has so broadened out that it is imperative that candidates with a thorough preparation for the basic training be secured—young women with initiative and mature judgment to whom any of us may entrust the care of some friend or relative who is ill; young women capable of meeting any important duties to which they may be assigned, medical, educational, social, or administrative; young women capable of making a healthy adjustment to their environment, be it private duty, hospital service, district nursing, public health work, industrial nursing, public school nursing, mental or rural nursing. These are but a few of the fields in which services of the nurse are re-

quired in cooperation with the physician in the prevention of disease.

The public, in presenting these duties to the nursing profession, should recognize its responsibility of adequately meeting the financial obligations incurred by the elevation of schools of nursing from the apprenticeship system to the status of a sound educational institution, with the schools giving a five-year course offering pupils an academic degree at graduation.

Aid Small Hospital Schools

Small community hospitals that have a school of nursing should be given every possible assistance to meet standards that will keep them on the approved list, for it is our small communities and rural districts that experience a shortage not only of registered nurses but physicians as well and the nurse whose social contacts have been largely limited to rural life is the one most likely to adjust herself to private duty, after graduation, in the community where she is already oriented and well known by the medical profession.

Arrangements should be made for state hospital affiliation. This would place the nursing care of the sick in our state institutions on a higher plane and would provide a needed contribution to the education of the nurse in the general hospital.

Some means should be found to standardize schools of nursing and registration, and central supervision by the state board of registration could be effected by the appointment of one or more supervisors. Every means possible should be provided to safeguard the pupils' physical and mental health during the period of practical work and instruction.

SHOULD PHYSIOTHERAPY BE TAUGHT IN MEDICAL SCHOOLS?

"Undoubtedly there are many men who realize in a way the necessity for more attention being given to the use and teaching of physiotherapy. One of the mid-western medical schools has been teaching it for two years, and the writer has had correspondence from members of the faculties of quite a few medical schools, more especially in the West. It was pleasing to receive a letter a few weeks ago in which it was announced that at least ten Class A medical schools will start next fall, the regular teaching of physiotherapy.

"At a meeting of the Association of American Medical Colleges held in Boston some time ago, Dr. W. H. MacCracken, dean and professor of surgery, presented a paper on 'The Teaching of Physiotherapeutic Measures.' This association is composed entirely of teachers of medicine and it was gratifying that such a group of men at their annual meeting took up the discussion of this need of teaching physiotherapy."—Norman E. Titus, M.D., in the *P. T. Review*.

THREE PROBLEMS THAT CONFRONT THE SMALL HOSPITAL

Nursing School—Intern—Public Relations

By C. A. Brimmer, Superintendent, Mansfield General Hospital,
Mansfield, Ohio

WHAT are the problems of the hospital in a small community? Most of the magazine articles and papers read at conventions treat the subject of the hospital and the small community in a vague and temporizing manner,

correct the lesser ones to which they contribute.

The purpose of this article is to tell what is being done at the Mansfield General Hospital, Mansfield, Ohio, in an effort to solve these problems and the results obtained at the present time.

Two years ago the number of students enrolled in our nursing school totaled eighteen and six of this number were to be graduated within two months. Although a new class was scheduled to start in September there were no applications on file. This was a serious condition for a seventy-five bed general hospital and called for an immediate audit of the situation.

offering much theory and little practical help. Many of the articles so presented are beyond doubt theoretically correct and the suggestions offered might well be applied advantageously if existing conditions permit. But the fact remains that the problems of the small hospital have not yet been discussed pointedly and plainly enough.

It is appreciated that every hospital has its individual problems peculiar to it in addition to three major problems that exist in approximately ninety per cent of all small hospitals, namely, lack of suitable prospects for the nurse training school; inability to secure competent interns; lack of appreciation of the hospital on the part of the public. There are, of course, many other standard problems but the solution of these three will almost always

A trial balance showed on the credit side, a school accredited by the state medical board; an excellent teaching staff of both medical men and graduate nurses; student allowances of \$8 per month the first year, \$10 per month the second year, and \$15 per month the third year; a new and beautifully equipped nurses' home; several high



Front view, Mansfield General Hospital, Mansfield, Ohio



Tennis court to the rear of the nurses' home. In season it is also used for a basketball court by the nurses, students and their friends.

school girls entering out-of-town nursing schools. The last item was included because it showed that nursing as a profession was not unknown to local young women.

On the debit side we found a lack of interest in the local school for nurses on the part of our Mansfield girls; a lack of recreational facilities and, as we found later, a lack of understanding of the younger generation of girls.

Corrective measures were undertaken at once

to visit each of the seven county high schools for the purpose of explaining nursing as a profession for women. A schedule was arranged and visits were begun on December 17, 1924. The writer acted as chauffeur and, as it turned out, was asked to talk to the boys of the schools on any subject desired. The talks were on the topic of responsibilities, and the Mansfield General Hospital was not stressed at this time. It was soon learned that these young men and women were



A view of the living rooms of the nurses' home

and some of our first attempts to create interest met with heartbreaking results. For instance, on one occasion we secured a list of fifteen names of girls who the high school authorities thought might consider nursing. To each was sent a carefully worded but cordial invitation to attend a radio party at the nurses' home, our idea being to meet and study them and from contact find out why they were not interested in the local nursing school. Of the fifteen invited one came long enough to explain why she could not remain and the other fourteen were never heard from. Other attempts met with similar results.

When things looked darkest, the county superintendent invited our superintendent of nurses

tremendously interested in our subjects and the intelligent questions asked and observations made by them gave us much food for thought. A cordial invitation was extended each school to visit the hospital and also to make use of our laboratory for teaching purposes. In each instance these invitations were accepted. Upon our request each principal gladly gave us a list of the senior girls and they were later mailed a copy of our training school brochure.

It soon became generally known that this program was under way, with the result that the high schools of the two cities situated in Richland County extended invitations to us to talk to their students on the same subjects. These last

two invitations alone placed us in touch with about fifteen hundred young women.

Because of the mid-year school holidays our program was not complete until the second week in January, 1925. We then wrote the principals of the schools in the surrounding counties asking them for a list of their senior girls, but we were exceedingly careful not to encroach on the territory of any other accredited training school. The reason for this is, of course, obvious.

In the very early summer the first fruits of our labor were apparent. Hardly a day went by that we did not receive several letters asking for information concerning the school. A rather surprising number of these applications came from cities or towns that we had not covered in our speaking tour, but we have reason to believe that our high school talks were directly responsible for receipt of these inquiries.

Campaign Secured Students

The direct result of our labors was apparent the first day of September when our fall term opened and we admitted to our probation class seventeen students, sixteen of whom were high school graduates, and one a two-year high school student who, in a short time, dropped out.

During the summer months the other item on our debit side, lack of recreational facilities, had also received consideration with the result that through the efforts of the male personnel of the hospital a tennis court was constructed to the rear of the nurses' home and was so arranged that later in the season it could be converted into a basketball court. The tennis court is much appreciated by the students and in pleasant weather it is occupied nearly all day. From the student body sufficient material for a first and second basketball team was available and through the kindness of the Y. M. C. A. an excellent coach was provided and through the helpful cooperation of the Y. W. C. A., courts were provided for winter use and our team was admitted to the church-school league. Other less strenuous types of athletics, such as kittenball and hiking were also introduced and a glee club was organized.

After reading this outline of recreational activity perhaps it may be thought that our school fosters all play and no work, but this is not true. Studies and class work are not neglected and we believe that our grades are generally higher than ever before.

In the mid-year class starting February, it was necessary to restrict the number of accepted applicants.

The second problem, that of securing the proper type of intern for the small hospital is not so eas-

ily solved. We are all familiar with the fact that with the increasing number of hospitals there are not enough medical students graduating from accredited medical colleges to offer a sufficient number of interns to cover the field. This pressure has been felt in the small hospital as well as in the larger hospital in the large city with the result that extremely unfair pressure has been brought to bear both on the small hospital and on the students graduating from medical colleges.

There are in every graduating class at least a few medical students who realize that the general practitioner is not a thing of the past. These students also realize that there is no better place in which to study the general run of patients than in a general hospital. To hospitals that have means of locating these particular students and of offering them a small salary in addition to their maintenance, the problem is readily solved and has been so solved in this hospital.

However, here again, the hospital must be sure that it has sufficient educational facilities at hand to make an internship valuable to the embryo general practitioner. The cases admitted for treatment must include all of the types that might ordinarily come to the office of a general practitioner.

The superintendent must be sure that his staff members recognize their obligation to the intern and not assume that the intern is a sort of high-class medical secretary. In a great many places teaching the older staff men to realize that the intern is a graduate physician and not an orderly is a great deal harder than getting an intern.

The Lack of Public Appreciation

And then we come to the last of the three major problems, the seeming lack of appreciation of the local hospital on the part of the public. It may be possible to paint a different picture to some of our readers concerning this particular difficulty. If we ask ourselves the question as to whether our general public fails to appreciate the hospital or only whether our healthy public fails to appreciate the hospital, we may have started in a small way to correct the lack of appreciation. In other words, in the well organized hospital that is delivering good service, the number of dissatisfied patients is extremely small and the number of satisfied patients turned out yearly increases automatically the number of appreciative people in a community. It seems then that the solution of the problem lies entirely in reaching those within the community who enjoy good health and teaching them to think of the hospital as a station of relief for a possible ailment. Ways and means of doing this are many and varied and probably de-

pend largely on the facilities at hand. Luncheon clubs, manufacturers' clubs, industrial clubs, National Hospital Day, and other such occasions all lend possibilities for the promotion of educational work.

But in educating the public we must think definitely and clearly on the matter of being sure that our hospital is giving the best possible service. It would be well for every hospital executive to sit down once a year and make an audit of the hospital's service, paying particular attention to the debit side, being extremely honest with himself and with his public in relation to the items that he places on the debit side and leaving no stone unturned to correct the items found there. It is true that many of the items will seem almost impossible of solution but by slow gradual progress, great things may be accomplished. In 1921 the Mansfield General Hospital had 9,899 days of hospital service. In 1925 the same institution, without enlargement, showed 18,393 days of service and so far in 1926 we have had twenty per cent more service than we did in the same period in 1925.

Publicity Value of News

The local newspapers are invaluable from the standpoint of public education, and the superintendent must not evade the news reporters. The smaller the community, the more this is true. At the Mansfield General Hospital we are convinced that the newspapers have certain obligations to the public concerning the health conditions of local citizens who are patients and ethical information is always given. This is also true of accident cases. We always report such cases promptly and give such details as are available. If, for some reason, it is advisable to refrain from printing anything about the case, we state our reasons at the time of giving the information and our confidence has never been violated. Many times such routine matters can be given in such a way as to become excellent publicity stories.

In this hospital we no longer consider that we are a small hospital in a small community but that we are a small hospital in a large community. Mansfield itself has not grown a great deal in the last two years but the hospital no longer relies on Mansfield for its patients. We have extended our field throughout the county and the surrounding counties and this extension has been largely due to the educational work started for the purpose of stimulating interest in our school of nursing. Nearly every small community within a radius of twenty miles of Mansfield has, at the invitation of its community clubs, parent-teacher associations, and the like, listened to speakers from our

organization explain the theory and practice of hospitalization.

The three outstanding results of our solution of the three major problems have been a one hundred twenty per cent increase in the population of our school of nursing, the assurance of an adequate number of interns, and twenty-seven per cent growth in the amount of service rendered by this hospital.

OREGON'S PROGRAM FOR PERIODIC HEALTH EXAMINATIONS

The plan for a college of health examination and efficiency research to promote health examinations in the State of Oregon is stated in the resolution recently adopted by the Oregon State Medical Association:

"In order that approved methods for examination of apparently well persons may be facilitated, it is proposed to select a faculty from the members of the Oregon State Medical Society who have shown themselves competent for making physical examinations in a creditable manner. They will organize a college of health examination and efficiency research to be known as the C. H. E. E. R. They will first qualify by being examined annually. Teamwork will be used for giving instruction and demonstration examinations before classes and medical societies.

"A postgraduate course of instruction will be open to all members of the society, provided that they agree to be examined themselves and to take a course of instruction in making thorough examinations. Particular care will be used in selecting instructors who have demonstrated their ability to do this work well. When a member of the society has completed one hundred examinations and filed his case records with the college, his application for fellowship will be considered. If the records are approved and the advice given by him is satisfactory, the faculty can then elect him a fellow. It is necessary, however, for every fellow, member, and student to go on record, stating he will be examined annually.

"This movement is to be popularized by practical demonstrations before local medical societies. It is of the utmost importance that every physician interested should not only be examined annually himself, but should make every effort to see that the members of his family also use this privilege. We would then be able to demonstrate to the public that we are not only taking our own medicine but are placing ourselves and our families in a position to enjoy longer life and better health."

CLASSIFYING GREAT BRITAIN'S PUBLIC HOSPITALS

In Great Britain there are two classes of public hospitals. First, the great voluntary general hospitals governed by private incorporated bodies and maintained by private subscription, catering for a selected section of the poor requiring the most skilled and specialized medical attention. The visiting staff are honorary and the hospitals are not a charge on municipal or state funds.

Secondly, the municipal hospitals or poor law infirmaries, maintained by city or county rates are catering for an equally large section of the poor who are suffering from chronic illness or whose medical condition does not demand the most specialized attention.

HOW CAN WE BEST CARE FOR THE CHRONIC?

By Ransom Sartwell, M.D., State Infirmary,
Howard, R. I.

POSSESSION or non-possession of money has automatically divided society into three classes, namely, the poor, rich and middle class. It has likewise made similar divisions for patients and has created difficult problems in providing care for each group.

The various forms of social service, charitable organizations and philanthropic movements, together with public funds from local and state governments, have made at least partial provision for the care of the poor when acutely ill. The wealthy are always able to provide adequate care for themselves, even though their illness may be of long duration, but the people of moderate means, that great mass of people known as the average wage earner, are able financially to provide ample care for themselves or families through an acute or possibly a sub-acute illness, but become absolutely helpless when faced by a prolonged illness. This is true because, throughout the country, no adequate provision has been made and no systematic effort has been worked out to provide suitable and timely care for the chronic patient.

The general public has very generously contributed funds for the building of general hospitals, making provision for the care of the poor, if suffering from an acute illness. The average wage earner can usually afford to pay the rates charged at the general hospital, or can pay for the necessary medical and nursing care at home, if the illness is only of a few days' or a few weeks' duration. As this class constitutes the vast majority of the admissions to general hospitals, it enables such institutions to be nearly, if not entirely, self-supporting, as far as maintenance and the general operating expenses are concerned. Therefore, with the provision made in most communities for care of acute illness, the average patient can be reasonably assured of adequate

medical treatment and care whether it be free treatment, if he is not able to pay, or treatment for such an amount as his financial status warrants.

On the other hand, if an illness becomes chronic, extending over a period of months and years, one cannot, with the existing facilities in most communities, be assured of adequate care. This is due to the fact that the implied and accepted function of the general hospital is to care for those suffering from acute illness and in order

to do this, with the number of available beds, it is necessary that patients be dismissed as rapidly as possible to make room for new patients demanding accommodations.

Assuming that the average stay of general hospital patients is ten days, one chronic patient, if he were to remain in the hospital six months, would prevent eighteen persons from receiving the benefits of the hospital. It is, therefore, I think, quite obvious that the general hospitals, as constituted today, are not

Shall the State Do It?

THAT no adequate provision has yet been made for the chronic is generally recognized. It is quite obvious, as Dr. Sartwell pointed out, that general hospitals are unable to take care of this class of patients. Yet some means will have to be provided for chronics who, unless treated in the early stages, become helpless and a burden on society. Since it is a public problem and since from previous experience in hospitalization, the smaller units of government seem incapable of handling it, Dr. Sartwell advocates that public opinion be directed to the end that state governments assume this responsibility.

able to assist in caring for chronic cases. If general hospitals were to fill their wards with chronic, free patients, they could not continue to function properly with the money available from public contributions, and the treatment of acute diseases would be defeated and their essential service to the community thereby lessened. Neither ought one to question the need of separate institutions to care for the chronic sick, when one stops to consider that today more people die as the result of chronic than of acute disease.

Statistics compiled by the Metropolitan Life Insurance Company, New York, show that organic diseases of the heart head the list as causes of death in middle life between the ages of forty-five and sixty-four years. Two other important causes of death during this period are tuberculosis and pneumonia, but the deaths resulting from these

two diseases combined do not equal those due to organic diseases of the heart. Statistics show further that one in five persons living at the age of ten will eventually succumb to organic heart disease. During the year 1924, heart disease together with its associated conditions forming the triad, cardiovascular renal disease, were responsible for claim payments by the company to the extent of 27.1 per cent of the total amount paid.

These statistics are mentioned because we are apt to underestimate the role played by cardiovascular renal diseases in determining the vital statistics of the country, as well as the economic loss for which they are responsible. The majority of these conditions are chronic and it would seem that this is a field in which there are opportunities for worth while and productive studies. If facilities in the shape of well-equipped hospitals, each properly manned with a competent personnel were available, there is no doubt that the rate of deaths due to this group of degenerative diseases might be very appreciably lessened and the time during which persons so afflicted are incapacitated could be much decreased.

Think of the amount of suffering and also time lost to the economic and industrial world that might in part be avoided were there adequately equipped hospitals to which persons suffering from chronic ailments might go during the early course of the disease and receive treatment and attention consistent with the seriousness of their affliction.

I wish to emphasize the fact that persons suffering from chronic diseases do not get the attention and the thought given to their condition that the outcome requires or should demand. This phase of the situation is brought out nearly every day in our work at the Rhode Island State Infirmary, an institution for the care of dependents, more than 90 per cent of whom are dependent as a result of a chronic illness.

Earlier Treatment Would Help

Many of them come to us after having suffered several years, during which time they have slowly but progressively become more helpless. The most pathetic part of it is the fact that many of them could have been helped if early, intelligent and conscientious treatment, such as their condition warranted, had been given. They invariably relate the same story of having gone from one physician to another, from one out-patient clinic to another and their description of the treatment received indicates quite definitely that they were not given early the type of treatment that is consistent with our present knowledge of medicine. In other words, proper interest was not shown.

The physicians or clinics "unfortunate" enough to receive these cases, as their histories would indicate, gave them medicines and treated them in a perfunctory way until they could gracefully unload them on to someone else, for no one and no general hospital wants to be burdened with chronics when acute cases demand its maximum capacity.

What is the result of this system, or lack of system upon the patient? Valuable time is lost, during which he should have received thorough and painstaking study and treatment. He becomes gradually worse and, in desperation, too often resorts to the use of patent medicines, or worse still, consults quacks who continue to treat him while his money lasts, after which he becomes a public charge.

If space would permit, we could cite from our records numerous cases to show wherein the cause of patent medicines and quackery has been enhanced and the cause of humanity lessened by the lack of interest taken by the general public and the medical profession in those suffering from chronic illness.

Many Are Industrially Productive

Out of about four hundred new admissions to the Rhode Island State Infirmary each year, approximately 40 per cent are between the ages of thirty and sixty-five, the period of their adult life when they ought to be industrially productive, rather than a burden and a liability. They all are incapacitated as a result of some chronic illness, which in many cases is so far advanced that it is evident from the first that they will need permanent institutional care, but there are others who respond favorably to treatment and if treated consistently are able to go out and, with the aid of an adequate follow-up system, become useful and self-supporting citizens for many years. These cases invariably require systematic medical and nursing care, together with regular habits, such as obtain in a hospital, for at least three or four months. Unfortunately, there are not in most communities hospitals that will or can accept them for this rather extended period, and as a result they receive inadequate treatment. Their condition grows worse until eventually unless they or their relatives are able to care for them at home, they must go to an institution for the remainder of their lives, not particularly for medical treatment, for they are usually beyond that stage, but for simple nursing or custodial care.

The difficulty of the chronic sick obtaining sufficient treatment undoubtedly has become more evident during the past two decades, because of the further development and greater activities of

the various health clinics, and because the visiting nurse associations, public health service and other organizations have unquestionably affected the vital statistics of the country, resulting in more people living to middle and past middle life, the period of life during which one is most liable to develop a chronic illness. For the same reason, the old law of the survival of the fittest does not hold, and many physically handicapped children, who twenty-five years ago would have died in infancy, are saved to adult life, yet they are never quite normal physically and are more susceptible to illness and are likely to become chronic invalids.

Demand Causes Rapid Turnover

Then, too, there are more people who go to general hospitals with acute illnesses today, and since the space in these hospitals has not increased proportionately, it has become necessary that the turnover of patients be more rapid, with the result that chronics are being turned out to make room for the acute cases. Many chronics, when sent out, go to homes poorly equipped to furnish the necessary care, as is evidenced by the fact that a comparatively recent survey of hospital facilities in Cleveland showed that 42.7 per cent of the cases treated in homes under supervision of the visiting nurse association were chronic cases and needed institutional care. Many, after being reduced to poverty, go to almshouses, city or county homes or town poor farms—institutions, the majority of which are not adequately equipped and whose officials have made no attempt to give their patients adequate medical care. This indifference exists in spite of the fact that a great many patients admitted to such institutions are in need of active medical or surgical attention.

A study of our admissions during the past five months shows that 35 per cent were bedridden upon admission, and it is very probable that the type of our admissions does not differ materially from that of the admissions to the average almshouse, city or county home.

Having shown, or having at least attempted to show the seriousness of the problem of providing suitable care for the chronic sick, it would seem appropriate to offer a few suggestions as to a plan by which this need might be met and ample facilities provided for treatment during the early stages of their illness.

The amount of study required correctly to analyze chronic cases equals, if not exceeds, that necessary to make a proper diagnosis of acute cases. To understand this study, sufficient equipment and an ample and competent personnel must be available, also suitable equipment and facilities

for treatment. This equipment and overhead expense are probably greater than most communities would be able to support by voluntary contributions, unless the institution is heavily endowed.

Therefore, it would seem desirable that the responsibility of providing institutions suitable for the care of this group of people be assumed either by the local or state governments and the expense met by public funds, those able to pay being allowed to do so insofar as is consistent with their financial resources. These institutions, whether they be called infirmaries, city or county homes, or what not, should in reality be hospitals with admission wards where patients may be intelligently studied and classified. Well-equipped hospital wards accessible to operating rooms, physiotherapy and special treatment rooms should be provided. Adjoining the hospital wards and also accessible to the special treatment rooms, should be wards for the care of those who, as a result of their disease, have become helpless and need a great deal of nursing care, but not close medical observation. There should also be wards having as attractive and homelike atmosphere as possible for ambulatory and, to a large measure, look after their own personal needs.

Occupational Therapy Is Useful

Provision should be made for occupational therapy which, in this class of patients, serves a very useful purpose, both in bringing about a more healthy mental attitude and in helping to improve their physical condition. This department requires careful and intelligent direction with therapeutic value always in mind. We have found occupational therapy to be one of our most useful agents in the care of semi-invalids and we believe that it possesses great potentialities not yet developed and not sufficiently used to bring out its latent beneficial qualities.

I have mentioned the necessity of providing suitable institutions for the proper care of the chronic patient by public funds and undoubtedly the question has arisen in the mind of the reader as to whether the state or local governments should assume this responsibility. Before forming an opinion, one should consider that the people of no community are exempt from chronic illness, and, therefore, the chronics from the small hamlets and sparsely settled districts, as well as those from the larger centers must be considered.

The larger cities could well provide suitable hospitals, but in the sparsely settled districts, it would be expensive for one or even two counties to build, equip, and maintain a satisfactory institution. If two counties combined, the element of

dual responsibility would complicate matters and very likely would not add to the effectiveness with which the institution functioned. It is quite generally conceded that it would be impracticable for any district smaller than a county to attempt to develop such a hospital. It seems to me that the county system is to be seriously questioned when one stops to consider the haphazard manner in which a great majority of the counties of the country are making provision for the care of their dependents. To me it seems unreasonable to expect so great a transformation in the attitude of the authorities of all the counties and no universally accepted standard can be expected without a central supervising and controlling body.

An analagous situation, a number of years ago, existed with reference to providing for the care of the mentally ill, when in many states the responsibility of their care was left to the counties.

Method Proved Unsatisfactory

This method proved unsatisfactory because of the deplorable manner in which some counties provided for their mental patients and because of public opinion. Through the efforts of the mental hygiene society, the county system in most states has been replaced by state care which has proved much more humane and satisfactory. What reason have we to believe that the counties, if allowed to determine their own standards of treatment for their chronic sick, will set up any higher and more satisfactory standard than they have for the care of their dependents or did for the mentally ill?

None whatever. And since we have some assurance that state governments could economically and effectively establish and operate hospitals or infirmaries for chronics, as has been done in regard to mental diseases and tuberculosis in many states, it would seem only logical to urge and help direct public opinion to the end that state governments assume this responsibility, being charged with the seriousness of the problem and made to realize that the erection of buildings alone will not make hospitals. In addition they should be adequately equipped and the appropriation be sufficient to allow them to be operated by a medical and nursing staff adequate in number to do scientific work consistent with our present knowledge of medicine and the demands of humanity.

In Natal, South Africa, the public general hospitals are maintained by the state government, a local governing body of management being appointed by the state government to represent the principal interests in the community.

SHOULD THE HOSPITAL HOUSE THE HEALTH CENTER?

Answering the question, why should a hospital house a health center, Dr. R. E. Wodehouse, secretary, Canadian Tuberculosis Association, Ottawa, Ont., gives the following reasons:

1. Because a modern city divides its medical costs for the year into two portions, practically equal in amount—\$1.50 a head a year for prevention of disease and \$1.50 a head for the care of its indigent sick.

2. Because the practice of prevention of unnecessary deaths is now limited to efforts to control exanthematous diseases. The three diseases killing the largest number of mature people, that is, of the ages of twenty to forty-five years old are: (a) tuberculosis (both in male and female); (b) (in women) childbirth and its complications, and (c) heart diseases (both sexes).

3. Because the hospital has all the technical equipment available to aid in examination for detection and treatment of all types of ailments. In addition, the expert medical men of the community are available and daily associated with the hospital.

He continues: "The hospital seems to me the natural center around which to build up any community medical service. The people already have the mental attitude which causes them in medical trouble to seek assistance there. It should afford the hospital management and medical staff a mellowing contact and broaden their outlook into that of preventing debility as well as remedying damage already done.

"The standardization of hospital records and practice should assure perfect service in the clinics, in so far as professional care and practice are concerned.

"It should allow the hospital to win the approval of many more citizens than that circle now coming within the knowledge of its good service, simply through aid given to a friend at a critical moment of life and death.

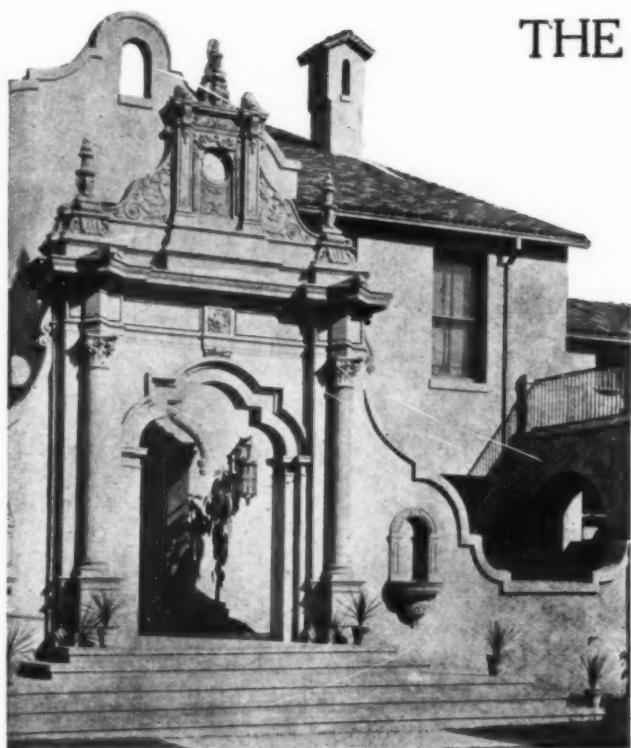
"It should grant nurses in training an opportunity for district follow-up work and study of social factors in regard to clinic cases.

"It should foster the practice of nationalized medicine along the lines the medical men prefer, or, effectively limit this tendency of development through the practice of the hospital accounting department which checks up clinic attendants as to their ability to pay for medical advice, at the offices of practitioners.

"In my opinion, whatever service is deemed desirable in a community could be best procured, from the point of view of expert attendance for the patient, and from an administrative angle, at a standardized hospital."

On the walls of the temples of Greece, Eos and Cos, were suspended white tablets, narrating the cures there effected. These displayed a strange medley of rational medical treatment and superstitious belief in the power of charms and incantations, and showed the mystic power of the priests declining before the increasing skill of the physician. These records, though scanty and imperfect, listed the diseases from which the pilgrims, who sought the shrines, had suffered. They became a sort of clinical record to which teachers and students referred, and was studied by those professional visitors who, even in those days, "walked the hospitals." However, the "walks" were longer then than now. Hippocrates spent twelve years in travel when pursuing his medical studies, and penetrated as far as Hindustan, where medical science was then more advanced than in either Greece or Egypt.

THE HEALTH INVESTMENT OF ONE COMMUNITY IN CALIFORNIA



Patio entrance, Long Beach Community Hospital

A FEW years ago the citizens of Long Beach, Calif., stimulated by several community leaders who realized that the city needed a hospital that could accommodate the wealthy and charity patients and still provide adequately for the needs of the majority of the population, promoted a movement for a community hospital.

For many years prior to her death, Mrs. C. H. Spence, a prominent club woman of the town, was at the head of the movement to obtain the necessary funds with which to build the community hospital. Her original plan was that the hospital should be so built that vast extension could be made without disturbing the administrative departments. This idea has been well carried out in the design of the Long Beach Community Hospital.

Under the leadership of Fillmore Condit, a councilman who later became president of the hospital association, the people of the town voted a bond issue of \$100,000 for constructing the hospital. Later when the plans had to be enlarged to meet the needs of the increased population the city council voted another \$100,000. The balance of the fund needed for building, approximately \$300,000, was raised by 1300 individuals, churches, banks, clubs and civic organizations.

A corporation was formed to handle all the affairs of the institution and its funds were pooled with those of the city.

The municipality entered into the major con-

tracts and drew upon the funds of the association when the city revenues became depleted.

The site chosen was the highest plot of ground in the vicinity accessible to the majority of the population. Toward the south, west and southeast the hospital overlooks the city. To the south and southwest it commands a view of the Pacific Ocean, Catalina Island, and to the east it faces the fertile valley of the San Gabriel River, broken by numberless rivulets and small streams.

The next step in the development of the hospital was the selection of the architect who would design the buildings to harmonize with the beautiful setting and embody the practical features of a municipal hospital. Hugh R. Davies, of Davies & Baume, architects, was awarded the contract. He chose the mission architecture of the Spanish padres and was successful in embodying the features of this style in an appropriate and striking design.

One of the distinctive features of the building is the patio. In front of the central portion of the building and enclosed on each side by two outer wings and on the front by an impressive colonnade, is this large court which is beautifully landscaped with shrubbery and flowers. Surrounding this court on the second story of the building and leading directly from the wards and



Solarium on the second floor of the colonnade

rooms is the upper portion of the patio which provides an outdoor and recreation porch for the ambulant patients who can enjoy the sunshine and fresh air without being disturbed by the noises of the street. The patio on second floor connects with a large solarium.

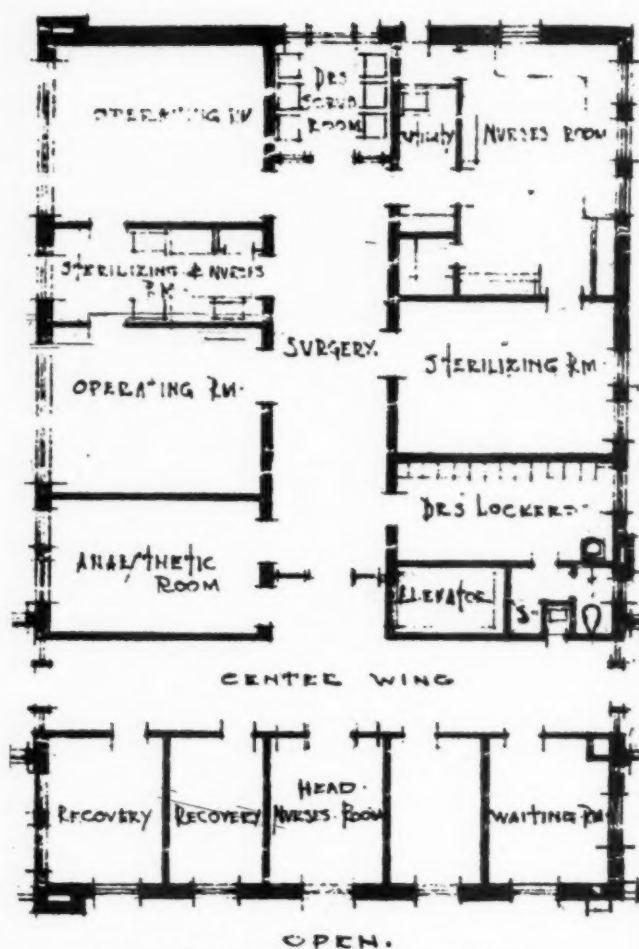
The physical plant consists of three buildings, the hospital proper, a three-story building, a two-story nurses' home and a laundry and power plant. As the ground floor of the hospital slopes abruptly to the east, the first floor is accessible only on that side. At the front the north and south wings connect with the main building by the long Spanish colonnade. At the rear, or east side, is the administrative wing.

On the ground floor with entrances to the east are the ambulance receiving room, main kitchen, nurses' dining room, lecture room, a large general storage room and seven wards. On the first floor facing west are the administrative offices with waiting rooms, pharmacy, record room, four wards and fourteen private rooms surrounded by porches.

The second floor contains the surgical department, five wards, ten private rooms, two balconies and a large solarium facing the west.

At present the building accommodates 150 patients and is so designed that its capacity may be doubled without necessitating major changes in the administrative portion and the various departments. The total cost of construction and equipment was in the neighborhood of \$400,000, or about \$2,700 per bed. This sum includes the cost of the nurses' home, which accommodates forty-two nurses, the laundry and power plant.

When completed, the entire institution was inspected and accepted by the city and then leased to the corporation, at a nominal rental, to be used by it for the purposes outlined in the municipal



Layout of second floor, administration building.

bond issue. In this way municipal politics is reduced to a minimum, although the city exercises control over the hospital through the lease.

Up to date, the hospital has been operating successfully from every standpoint, and the objective of the founders, that the burden of maintenance should be divided fairly among the patients, taxpayers and charity patients, is being carried out in practice to a decidedly successful degree.



The colonnade connecting the two wings of the Long Beach Community Hospital.

THE RURAL HOSPITAL PROGRAM OF THE COMMONWEALTH FUND

By H. J. Southmayd, Director, Division of Rural Hospitals, Commonwealth Fund,
New York

THE tradition that the country takes precedence over the city as a healthful place of occupation and abode is passing. Over a relatively long period of time death rates both in the city and country have been markedly reduced, but during the past generation the reduction in rural mortality figures has not kept pace with that of city rates and there is today, in many instances, a surprising discrepancy.

So long as the country districts remained on a par with the cities in this respect the status of rural health invited no particular attention. The "old oaken bucket," for a number of years, has been recognized as a possible menace to health. The realization of the greater prevalence of water borne disease and other communicable diseases in the country stimulated effort for better rural sanitation and the organization of public health departments comparable to urban activities. Recent vital statistics, however, give additional advantage to the city in maternal and infant mortality. Examinations of school children show a relatively high percentage of physical defects in the rural group. These and other indices now point to a need for still further improvement in the rural health field.

That this can be accomplished only by conscious effort is evident from past experience. While much of the reduction of disease and death can be credited to advanced standards of living, rural standards generally have risen with city standards, and the increasing disparity in the health status of the two groups, which still exists, obviously cannot be attributed to this factor. This trend probably is of as great importance as any

other phase of comparative urban and rural life. Granting that the general difference in living standards has had an approximately equal effect, relatively at least, on urban and rural life, the explanation of the existing disparity must lie largely in the degree of efficacy of conscious effort to improve health conditions.

In itself the progress in the public health of our urban communities, brought about by conscious effort, is a remarkable achievement, accomplished, as it has been, in scarcely more than a generation. It lends encouragement to the belief that a similar result may be reached in rural areas in a lesser period of time, since much of the experience and knowledge gained in urban work is available and applicable to a rural program.

Fundamentally, the same principles apply, though different methods are indicated by an extreme difference in population density. The extensive public water works and sewage systems of the city are neither necessary nor

practicable in rural areas. Progress in the reduction of water borne disease, nevertheless, is being made in the country by education in the safeguarding of private water supplies, inoculation against typhoid and other less expensive but effective preventive measures.

Likewise, it is to be expected that methods and facilities devised to reduce maternal and infant mortality in rural districts will vary from those used in the city. The scattered population, the difficulties of transportation and other characteristically rural conditions indicate the necessity for the special adaptation of any program and suggest the importance of a much greater use of

What Is Being Done

TO FAVORABLE applicants the Fund will contribute two-thirds of the building and equipment cost, furnish plans and specifications for building, and advise in the planning, construction, equipment, organization and operation of the proposed hospital.

Rural areas eligible to selection are those that do not possess general hospital facilities of reasonably adequate and accessible character within a radius of thirty-five miles and that do not contain within that radius an urban center of more than twelve thousand population. An additional primary requisite for eligibility is the assurance of general and active community interest in the project and the cooperation of leading members of the medical profession and of agencies now engaged in health activities.

health education in insuring self-protection, and of the development of institutions with a wider range of activities than those in the city, both geographically and functionally.

The Commonwealth Fund, engaged for some time in various public health activities and increasingly cognizant of this widening breach between urban and rural health, was attracted to the consideration of the rural health question as a whole. It seemed no unwarranted assumption that an interrelationship existed between higher rates of mortality and the lack of facilities to combat the situation in country districts.

It did not need to be argued from a humanitarian standpoint that the country district is inherently as much entitled to health protection as the city; nor was it necessary to consider the relative importance of rural health or the significance of the trend of rural population to the cities. The real questions to be answered were: Does the relative status of urban and rural health indicate a practical opportunity to improve the situation? What is the most practicable method of approach in view of the growing importance of preventive work as compared with remedial? What line of effort offers the best improvement on both the preventive and remedial sides?

Rural Sections Need Trained Personnel

It was not difficult to determine in broad outline the greatest needs of the rural sections of the country. The most important are trained personnel—physicians, nurses, health officers—and modern institutional facilities, such as hospitals, dispensaries and health centers. It was clear that no one organization could hope, within the limits of reasonable expense, to devise and carry out a plan capable of meeting all of those needs even in a relatively restricted area. The problem was rather to develop a method of approach which, potentially at least, might create an influence toward the supplying of those needs, both personnel and facilities, and which at the same time would enlist local interest and support and provide a medium through which could be developed various types of health activities.

On the whole, the hospital seemed to offer the best single means to this end. The hospital, of course, like the practicing physician, is usually classified as a remedial agent. This is a purely arbitrary classification and is today scarcely justified. Just as the practicing physician is increasingly undertaking preventive measures and medical schools are more and more emphasizing this phase of professional work, so are progressive hospitals coming to be regarded as educational health centers quite as much as institutions of re-

habilitation. The hospital, therefore, particularly in its out-patient department, has excellent possibilities for preventive educational work in the community. Moreover, the hospital as an institution capitalizes local pride and from the nature of its activities excites almost universal support. It meets a generally recognized need; the service it renders is definite, tangible. These facts, with the investment represented, give reasonable assurance of permanency and development.

Institutions' Influence on Local Practices

A further factor of primary importance is the influence of such a medical institution on local medical practice. The hospital centralizes the work of the physician and enables him not only to increase his practice but to improve the quality of his work because of the facilities afforded for diagnosis, treatment and constant medical and nursing supervision of his patients. These advantages should have an appreciable effect in increasing the ratio of physicians to rural population, which is well known to be much lower than in urban centers, though the very nature of the rural situation demands, if anything, a proportionately larger personnel to give anything like comparable service. In some country areas this ratio has declined to acute proportions, as established physicians are leaving the rural communities and recent medical graduates are failing to replace them. It is generally agreed that the lack of hospital facilities and of the stimulus of hospital contacts has been a factor in the situation.

On the basis of these various considerations, and with recognition of all the possibilities of the hospital as a potential health center inevitably bringing about the development of a community health consciousness, the Commonwealth Fund some months ago drafted a tentative program for the granting of advice and financial assistance to selected rural communities in the establishment of hospital facilities. The plan was submitted to a number of interested and authoritative individuals and organizations and met with practically unanimous approval. In order better to test its practicability, an authority in the hospital and institutional field was engaged to make a field study and, if it seemed feasible, to choose the first community to participate in the program. The report was favorable to the inauguration of the program; the first community was selected; and as this is written, plans for the first hospital at Farmville, Va., are in the hands of contractors.

The investigator's report concurred in the suggestions of the tentative program, that eventually additional service might be rendered in the reor-

ganization of existing hospitals and the development of other means for improving local medical standards and making rural practice more attractive to the profession. For the present, however, the activities of the Fund will be confined to the construction and organization of new hospitals along approved and progressive lines in accordance with the following general terms of the program.

Assist Two Hospitals a Year

Financial provision is made by the Fund to assist two local rural communities each year in constructing and equipping hospitals, each adapted to particular local conditions. Rural areas eligible to selection are those that do not possess general hospital facilities of reasonably adequate and accessible character within a radius of thirty-five miles and that do not contain within that radius an urban center of more than twelve thousand population. An additional primary requisite for eligibility is the assurance of general and active community interest in the project, and the cooperation of leading members of the medical profession and of agencies now engaged in health activities.

In the case of applications favorably acted upon the Fund will contribute two-thirds of the building and equipment cost, furnish plans and specifications for building, and advise in the planning, construction, equipment, organization and operation of the proposed hospital. The local community is expected to cooperate in the enterprise by providing the site and one-third of the building and equipment costs, and by guaranteeing annual operating and upkeep expenses of the institution. For the present it is unlikely that financial assistance will be given by the Fund to complete the building or equipment of projects under construction, to make additions to existing facilities or to remodel structures now in operation for hospital purposes.

General Hospitals for Acute Cases

It is understood that the institutions thus established shall be general hospitals of from forty to sixty bed capacity for the care of acute conditions, and that medical service shall be available to all residents of the area without regard to color, race, creed or economic condition. Modern facilities for diagnosis and treatment, such as laboratory and x-ray, will be included and special provision for maternity care will be made in each instance. The hospitals are not to be designed for the admission of contagious diseases but will be provided with isolation facilities for such emergency cases as may develop. Out-patient activi-

ties are planned as an important branch of the general service in the expectation that the institutions will contribute to the development of general community health standards along educational and preventive lines. Where local conditions permit, nurse education is to be undertaken, and intern training is to be combined with resident medical service.

It is expected that these hospitals will be operated under generally approved standards of service and their facilities made available to all ethical physicians in the community for the benefit of their non-hospital as well as hospital patients. Administration of each institution will be vested in a local private, but non-profit making corporation, the Commonwealth Fund assuming no administrative responsibility for either construction or operation.

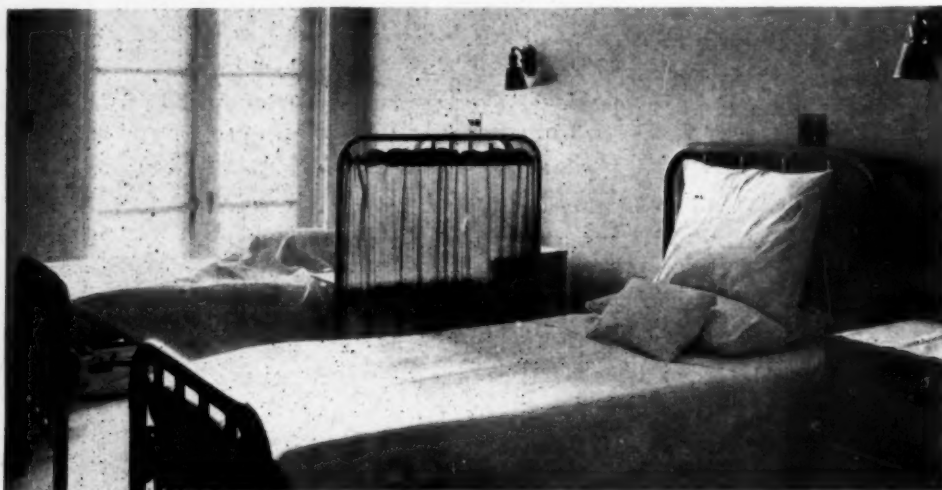
Number of Appeals Were Many

The announcement of this program was followed immediately by a gratifying, though almost embarrassing, number of appeals from more than half the states in the country. Not all came within the provisions of the program, some representing large urban centers and others disqualifying as requests merely for assistance in meeting building or operating deficits. Even with these eliminated, the number of appeals deserving consideration is sufficiently large to indicate a most satisfactory response to the program and an appreciation of the hospital as an instrument of health in rural areas, which offers no small assurance of the success of the venture. The first community selected was in the southeastern section of the country where there seemed to be the greatest need for hospital facilities. Because of the necessity for concentration of activities in the interests of economic administration it is probable that the second selection also will be made in that same section. Appeals from all parts of the country, however, are being studied as a basis for future activities.

The program is in no sense final, its details by no means crystallized. It is launched with full recognition of community variations and the necessity for local adaptation in each case. The plan is in reality an attempt to test a particular method of approach to the rural health problem, an experiment based on the belief that the hospital, as an essential and central figure in any community, is a logical starting point for a comprehensive health program and offers the greatest promise as a point of stimulus to community initiative and responsibility in the development of sound health measures and in the furtherance of control of disease in sparsely settled regions.



Above, a typical ward at the Babies' and Children's Hospital, Cleveland.



*Three
Different
Types
of Wards*

Above, a typical two-bed ward at the Maternity Hospital, Cleveland. Below, roof ward of the Babies' and Children's Hospital, Cleveland.



STUDIES ON HOSPITAL PROCEDURES

THE CRITICALLY ILL PATIENT

SHOULD a patient become critically ill, the spiritual and physical resources of the hospital are taxed to the uttermost. At this time, the greatest degree of tact and what may be called the art of hospital practice are called upon not only to soften the ordeal through which the patient must pass, but also to perform a like service for his relatives and friends.

Not infrequently, the notification of relatives, that the patient is in danger, is performed in a manner that is not conducive to sparing mental pain. If possible, this information should be transmitted through a home visit by a tactful person, possibly from the social service department. If this is not feasible (and it will rarely be so in an institution of size), the telephone may be used to convey this message. If this plan is adopted, tact and understanding must be possessed by the person to whom this duty is assigned. Merely to announce to the anguished wife by telephone, that her husband is in danger of death, or that he has expired, represents the lowest degree of tactful procedure. If notification by this means is impracticable, then the telegraph or the mails may be employed. This message should be so carefully worded that a mistake concerning its import is impossible and yet, at the same time, that the shock of the news it carries may be lessened.

At no time can a sympathetic understanding of the mental state of the distressed relatives be more practically expressed than when these persons arrive at the hospital in response to a summons to visit a dangerously ill patient. A comfortable waiting room should be provided in which the relatives may pass the anxious moments during which they are excluded from the patient.

The nurse and the doctor, as well as the ward attendants, should be thoroughly schooled in their contact with these persons. In many institutions it is not necessary for a patient to pass his last hours among others in a general ward. When the danger notice has been dispatched, or even before this time, the patient is often moved to a small room adjacent to the ward where nursing care can be more scientifically and efficiently admin-

istered, and where friends and relatives can be alone with the patient. If this is not possible, ward cubicles constructed of metal or glass, or even formed by linen curtains, are of the greatest utility.

Nursing and Medical Care of the Critically Ill

From the beginning of time, there has existed in the minds of professional and lay people the question as to the ethical demands upon the physician, when he becomes convinced that the death of his patient is inevitable. Shall the patient, suffering with an incurable disease, as death approaches, be kept alive by means of stimulation and supportives, and his departure be thus postponed for minutes or hours, or shall the doctor, knowing that neither the service of therapeutics nor all the skill that medical specialists possess will avail, simply relieve the patient of pain, and await the certain outcome?

It is not the function, nor within the scope of this article, to attempt to answer this question. It should be sufficient to say, however, that neither the physician nor the nurse will withdraw from the patient any service or remedy within their power which, within the greatest stretch of the imagination, may be life-saving. Nor will one moment of pain be allowed that, in any way, can be prevented.

The mental attitude of the nurse and the physician must not betray to the patient their anxiety as to his condition, and thus add to his suffering. On the other hand, a light or semi-frivolous attitude, although intended as a mental support to those around the stricken man, may be misinterpreted as reflecting a careless or unsympathetic attitude toward suffering on the part of the nurse or doctor.

Whether the adoption of a policy of deception is justifiable or ethical in so far as withholding from the patient a knowledge of his real condition is concerned, is another question concerning which there is a great diversity of opinion.

There are many things that the skillful nurse may do that will usually add greatly to the patient's comfort, for even though to the physician and nurse death of the patient is inevitable, a visible continuance of curative effort will greatly minister to the peace of mind of the sick man's relatives, since, in the non-medical mind, as long as the patient breathes, there is always a hope that a sudden change may bring him back to health. The cleansing of the mouth, the moistening of fevered lips, the adjustment of disarranged pillows, the smoothing of bed clothes, attention to the ventilation of the sick room, a

tactful absence when friends arrive, are all steps that will suggest themselves to the skillful graduate nurse.

Nor should those in attendance overlook the fact that it is oftentimes of the greatest importance, from the standpoint of both the patient and his relatives, to make provision for the attendance of a minister of the gospel.

Then, too, it should not be forgotten that before consciousness is lost, it is usually best to inform the patient, in a tactful way, of his danger, in order that he may be able, if he so desires, to make arrangements concerning the disposition of property, or the visitation of his spiritual adviser, his relatives or friends.

Experienced hospital superintendents have observed, on not a few occasions, the mental shock that comes to the young physician and nurse when they are first brought face to face with death in the patient for whom they have been caring. It would indeed be a fine thing if neither the nurse nor the physician should ever have to undergo this ordeal. It would also be an end much to be desired if a sensitive reaction as to the loss brought by death could always exist in these persons. To become accustomed or callous to physical and mental anguish is to lose a great quality that is most difficult to replace.

Oftentimes the young physician and nurse sorely need the advice and the support of those older than themselves during these early and trying days in their professional lives.

Records—Death Notices

After the patient has expired, the first official act of the physician is the pronouncement of death. In the lay mind, there has always existed a fear lest, at this time, a mistake should be made by the physicians, and that death would be pronounced when life actually existed. Fortunately, medical literature does not disclose that this accident has taken place anywhere in the history of the world.

Until the physician has pronounced the patient dead, the nurse is not permitted to make any preparation for the removal of the body. Indeed, it is considered most unethical for the nurse, on notifying the ward physician of what has transpired, to express any opinion, except to say that the patient had apparently ceased breathing. Usually, the physician, after examining the body to make certain that life is extinct, fills out an official form notifying the hospital office that the patient has died. On this form is inserted the name and age of the patient, the department and ward of the hospital, the date and hour of admission and death, and usually the final diagnosis. Frequently also, the hospital office is notified by

phone as to what has taken place, in order that immediate information may be dispatched, in the manner suggested above, to those interested. The death certificate need not be executed until some time later, since the preparation and removal of the body from the ward will require considerable time.

Preparation of the Body

The same care and tenderness should be shown to the body of the expired patient as would be shown prior to death. In no finer way can a hospital express its spirit of humanity toward its patients than in observing every refinement of technique in the preparation and removal to the hospital morgue, of the remains of patients who have died within its wards and rooms. In no less degree, should the hospital executive remember that he must spare the remaining patients in the ward the oftentimes gruesome display incident to the removal of the body of a patient who has died there.

The manner in which this removal is accomplished depends largely on the geography of the hospital in question, and hospitals must, therefore, be governed in this procedure by the arrangement of ward units. If a small room has been utilized for the dying patient, this procedure is simplified. If the patient has expired in an open ward, sometimes a lane of screens is so arranged that patients in the ward are unable to view the process of removing the patient's body. Oftentimes a route from the ward to the morgue, which utilizes little used corridors and service elevators, will prevent a view, by visitors or other patients, of this procedure, which sometimes has a disturbing effect. In this matter the importance of consideration for others cannot be overestimated.

It is a wise plan to so prepare the body and the stretcher coverings, that to the casual observer at least the journey to the morgue appears simply as a transfer of a patient from one department to another.

Preparation of the Body by the Nurse

There is no generally accepted method for the preparation of the body by the nurse before removal from the wards. The technique detailed below, adopted in the Methodist Episcopal Hospital, Philadelphia, may be used as a type of procedure suitable for this purpose:

The nurse may take no steps toward the preparation of the body until the doctor has pronounced the patient to be dead.

While waiting for the physician, the body is placed in the dorsal recumbent position, limbs straightened, the head and shoulders elevated on two pillows and the hands crossed on the chest. The eyes are closed.

If false teeth were worn, these should be inserted at once, the mouth closed and chin supported by a folded towel or roller bandage. Remove ice caps and hot water bottles from the bed, and cover the body with one sheet.

After the doctor's visit, if this has not already been done, remove all rings or valuables and dispose of them according to the local hospital rules.

If there be a wound, replace soiled dressings with fresh ones, and if drainage tubes and artery clamps have been employed, remove them. Remove marks of adhesive plaster with ether.

Bathe the body with soap and water, and rinse with 3 per cent cresol solution.

See that the nails are clean.

Fold a square of old muslin cornerwise and put a pad of cotton in the center, and slip this under the buttocks and place the pad against the rectum. Pin the muslin in the same manner as one does a child's diaper. Comb the hair and support the jaw by placing a strip of four-inch bandage under the chin, tying the ends on top of the head. A second strip of the same width of bandage may be brought up behind the ears to aid in keeping the mouth closed. A roller bandage under the chin also helps to keep the mouth closed, and eliminates the necessity of tying the bandage too tightly. This is to be avoided, if possible, as it tends to produce discoloration of the tissues.

Fasten the lower limbs together at the ankles and knees, being careful not to tie the bandages too tightly.

Fasten the elbows together so as to keep the hands elevated on chest, when moving the body.

Write the name and address on a tag and fasten to the wrist.

Wrap the body in a discarded linen sheet, or a paper sheet made for this purpose may be employed. Tie at the ankles, around the body and about the neck.

The body is now ready to be sent on a stretcher to the mortuary.

In some hospitals, a shroud somewhat similar to an ordinary bed shirt is used to clothe the body. This can be made from a cheap grade of muslin, with the expenditure of but little time and money. A wrapping sheet of the same material is often used either in lieu of, or even in addition to, this garment.

It is customary for the clothing and any other minor effects of the patient, which have been kept in the ward, to be placed in a bundle, and after an inventory tag is attached, to be sent with the body to the morgue.

In most modern hospitals, great care has been taken to provide refrigeration facilities for the proper preservation of the bodies of the dead. Here the same degree of care as outlined above should exist relative to the careful and respectful handling of these bodies by those who perform the postmortem examination.

Postmortem Permissions

It will not be possible, in the space allotted to this article, to detail the various methods that have been found useful in securing postmortem permissions. It should be sufficient to say, however, that no hospital that does its duty to its

community, and to the advancement of scientific medicine, will spare any effort in maintaining a high annual percentage of postmortem examinations.

Frequently, a permission similar to the one shown below, will be signed and duly attested before the patient dies. This may be secured as soon as the outcome of the case is evident. If such permission has not been secured before death, it is just as much the duty of the physician to endeavor to secure the signature of an authorized person to this form as it has been his duty to spare no effort in his endeavor to bring about a return of the patient to health:

.....192....
 "I,, the nearest relative, hereby give permission to have a complete autopsy performed upon the body of
 (including brain and cord, when necessary)
 in case of death, the attending physician deeming such necessary for the good of the institution.
 "I also agree to make arrangements for burial and to defray all funeral expenses and to remove the body within 36 hours after death."

Name

Address

Witness

Postmortem Examination

The postmortem room in the hospital laboratory should be large, airy, well lighted and as clean as the operating room in the same hospital. Nor should the morale of this room, during the carrying out of a postmortem examination, be in any degree lower than that in the room where scientific surgical procedures are carried on prior to the death of the patient. The wearing of hats, smoking or any form of hilarity by spectators or those engaged in the performances of such an examination are not conducive to maintaining the high morale that is desirable in the post-mortem room.

When the body of the patient has been placed on the postmortem table, the carrying out of the technique incident to this examination should have no aspects that would lead the casual observer to decry the necessity and the manner of conducting these examinations. The patient's clinical record should be at hand, the pathologist having had an opportunity to read this record before beginning his examination. A stenographer or some mechanical recorder should be provided to take dictation as the examination proceeds, and to note the location of sections taken for histologic studies. The resident and visiting physician who cared for the patient, prior to death, should have been notified as to the date and hour of this procedure. Every effort should be made to make each postmortem examination

a clinico-pathological conference in miniature, at which the clinician and the pathologist jointly strive to clear up any diagnostic problems connected with the case in question.

The postmortem examination having been completed, the body is now prepared for delivery to the undertaker. All of the technique that has been carried out in the hospital wards will be unavailing unless the person in charge of the morgue is equally as meticulous in the removal of any gruesome evidences incident to the postmortem study and in the manifestation of a careful, respectful attitude toward the former patient's earthly remains.

The Mortician and the Hospital

There appears to be but little doubt that in some localities, the somewhat unfriendly attitude of morticians toward the hospital itself, and particularly in regard to the question of performing postmortem examinations, can be traced to the presence of hospital faults that could be remedied with but little effort on the part of the superintendent. The chief complaints of undertakers relative to the hospital, may be summarized as follows:

1. . . . There is often too much delay in the delivery of death certificate and the effects of the deceased.
2. . . . Frequently, inaccurate information given out by the hospital as to when the body will be ready for delivery, causes preventable expense of time and money to the undertaker.
3. . . . Lack of a proper technique in the performance of postmortem examinations unduly interferes with the later embalming of the body by the mortician.
4. . . . Faulty technique in the examination of the spinal cord and brain makes the mortician's work more difficult because of the almost impossibility of preventing leakage.

Frequently, undertakers are required to rent, on an hourly basis, conveyances for the removal of the body from the hospital. Avoidable waits, therefore, cause no little extra expense to them. The hospital should, if at all possible, arrange to have the certificate of death and any other necessary documents, ready at the time the mortician calls, in order to obviate the delay that is a frequent cause of complaint by the mortician.

Too frequently, this delay is produced by a telephone clerk informing the undertaker that a certain body will be ready for delivery at a definite hour, and then, because of a change in the hour set for the postmortem examination, or for one of a dozen other reasons, the body is not to be secured when his conveyance arrives at the institution.

It appears superfluous to state here that all incisions should be so located, that when the body

is prepared for burial, there will be no evidence of a postmortem examination having been performed. Since the main arterial trunks are usually incised in the course of the routine examination, the ease with which the body is prepared for burial will be facilitated by slight alterations in the customary postmortem technique.

Below will be found a number of suggestions that have been jointly agreed upon by the hospital association and the embalmers' society of one of our eastern cities:

The hospital agrees to request its pathologist:—

1. To tie off all large arteries and veins severed in doing his work after the blood has drained out. (The vessels tied are the following: the innominate, the left carotid and the left subclavian arteries, and the two innominate veins in the neck; the renal arteries, the celiac axis and the superior and inferior mesenterics. In case the aorta is removed, to tie both femoral arteries and veins. The thread attached to the vessels in the neck shall be left at least eight inches long.)
2. If intestines are removed, to tie off the rectum.
3. To sew the body neatly, to wash off blood stains and to present the body in as neat a condition as possible.
4. If the brain is removed to make the scalp incision from behind the ears leading over the occiput and remove the posterior portion of the skull, to tie off the carotid arteries at the base of the skull, pack the foramen magnum tightly with cotton and fill the skull cavity with a hardening compound. To sew the scalp neatly.
5. To perform the autopsy at the earliest possible hour, and when consent is obtained for it, to indicate to the family the hour at which the body may be obtained by the funeral director, the hospital also to notify the funeral director.
6. The death certificate to be signed immediately after the autopsy by the doctor in charge of the case, or his intern, and left at the office of the hospital.
7. In case the body is that of a woman, the Y incision shall be used in all cases possible by the pathologist.
8. Although permission has been granted by the family for an autopsy no unnecessary incisions will be made.

The pathological society will urge upon the nursing staff of the various hospitals the necessity for the proper binding of the arms around the elbows instead of the wrist, also supporting the chin, of all bodies.

It will also urge upon the hospital authorities the necessity for proper fixing of the morgue boxes so that the head of the corpse will be elevated, and to advise the hospital authorities of the desire for elimination of favoritism in the choice of a funeral director.

The funeral directors on their part will assist the pathologists in obtaining autopsies and cooperate with them to the fullest extent.

It does not seem that there is anything unreasonable or unfair in these statements. The adoption by hospitals, generally, of suggestions of this sort, would certainly produce a better understanding between hospitals and undertakers.

Whether the hospital should make a stated

charge for the shroud which is used in clothing bodies, is a matter that must be governed by local conditions. If, not only a muslin shroud, but a wrapping sheet has been used, the expense to the hospital for each body will approach fifty cents. If there is any objection on the part of the morticians toward a small charge covering this item, it no doubt would be better for the hospital to defray this expense, since this procedure is certainly one that adds a touch of refinement, from the institutional standpoint, to the general care of the dead.

It is the custom in some hospitals, to offer facilities to the mortician for the embalming of bodies, particularly where early shipment by train is to be made. Indeed, some hospitals furnish the instruments required for this procedure as well as the fluid used.

Undertakers often appreciate an opportunity to embalm the body immediately following the performance of a postmortem examination, before the routine incisions have been sutured. This is just one more act of accommodation on the part of the hospital, which is trifling in expense, but which will surely yield as one result an increase in postmortem percentages, because of the lessening of opposition to this procedure on the part of the undertaker.

Infectious Bodies

Most states, cities, counties and boroughs have definite regulations that have been promulgated by their local boards of health, relative to the question of preventing the spread of disease through the careless handling of bodies of patients who have died from contagious diseases. The bodies of patients who have died from scarlet fever, diphtheria, small-pox, cerebrospinal meningitis, poliomyelitis, etc., and even the so-called minor contagions, that is, measles, whooping cough and chicken-pox usually cannot be buried with the customary ceremonials because of the danger of spreading the infection.

From the standpoint of the hospital, such bodies must be properly designated as "infectious," and to prevent any mistake on the part of those in charge of the mortuary, the records, including the death certificate, are usually plainly stamped with the word, "infectious," to indicate that the condition from which the patient suffered, could be transferred to others by contact.

Boards of health usually require that no public funeral take place, that the casket be sealed and not opened after the body has been prepared for burial, and that certain regulations relative to the shipment of the body by means of a public conveyance, be observed. The performance of a

postmortem examination is rarely permitted by health authorities in this type of case. These regulations undoubtedly work a hardship to the patient's relatives, both from the standpoint of expense, as well as from a sentimental viewpoint, but it is the plain duty of the hospital to deviate not at all from pronouncing a body infectious if such were the case, and of the proper notification to health authorities to this effect.

The Hospital and the Coroner

In all cases where there is a possibility that death has been due to foul play, mal-practice or where the patient has not been under treatment in the hospital longer than twenty-four hours, the responsibility of determining whether any person or persons were responsible for, or contributed to the patient's death is left to the local coroner. It is the hospital's duty to see that the opportunity for the taking of an ante-mortem statement is given to the local law-enforcing officers before consciousness departs from the patient. This is an important point that should not be delayed by the institution.

After death has taken place, in such cases, it is the function of the hospital not only promptly to notify the coroner's office, but to present any facts that may be of aid to this office in determining the cause of death, and the responsibility therefor.

In cases referred to the coroner, the hospital usually is not permitted to execute a death certificate, this document emanating from the coroner's office.

COST ACCOUNTING SYSTEM SAVES MONEY

Do you know what the per diem cost per patient of your hospital is? Do you know what percentage of your total expenditure is for administration and for the different departments? Can you tell to the fraction of a cent what your ration cost is? If you can, you have a good cost accounting system. If you cannot, wouldn't it be a wise idea to install one? It is the pennies that count in hospital administration. If you can save a cent a day on your per diem, and you have an average of 300 patients in your hospital, you can effect an annual saving of \$1,095. There are a multitude of little wastes that keep gnawing daily at the funds for the support of a hospital. Careful cost accounting enables the hospital administrator to check up on these and to eliminate them. A thorough and accurate system of this character can be installed for \$1,200 a year for a 250-bed hospital and it will pay for itself many times over.

Do you have an inspection made regularly of your trash cans? It is remarkable how much valuable property finds its way into the trash cans. Table silver, dishes, glasses, ward slippers, stomach tubes, hot water bottles and similar articles, many of which are capable of repair, may be discovered. This is a source of loss that can be checked by inspecting trash cans from time to time.



The MODERN HOSPITAL

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THE ADMINISTRATOR'S RIALTO

TO GLOBE trotters, the famous Rialto Island and Bridge of Venice are familiar sights.

To those not so traveled, it is necessary to recall that these represent the place of exchange, the market of this justly famous city of canals. Where men and women gather together, be it for commercial gain—for the buying and selling of goods—or for the furtherance of some less material and more worthy project, each acquires knowledge by intercourse with others from climes both near and far.

The rialto of the administrator is the annual meeting of the American Hospital Association. Here the hospital executive brings his problems, his successes, his failures, and here also, he often finds, among the wares of a brother administrator, the solution for which he perhaps has hitherto vainly sought. The answers to many perplexing questions are here to be gained for less than the asking—for merely the listening. But a visit to a convention, to be of greatest benefit, must be something more than mere physical presence. It is a time not of barter, but of exchange of ideas, of experiences. It is a period when good fellowship obtains, when that restraint so commonly, unconsciously present is shed as a garment, and all else is forgotten in a common search for better and surer ways of restoring health to those to whom disease has come.

WHAT IS REAL EDUCATION?

THERE are two subjects in which every human being is interested and about which he is entitled to have an opinion regardless of the state of his knowledge. These are the practice of medicine and education.

Satirical as this remark may appear, it is but logical that this should be so since upon the health and education of the people depends the integrity of the human race. To any one who has thought about the matter, there is one point which stands out and that is, that the general public is not wholly satisfied with either one. This is a most hopeful sign because upon this dissatisfaction depends much of the stimulus for improvement and growth, and as a result physicians and sanitarians are constantly endeavoring to improve methods for the cure and prevention of disease, while educators are striving to extend real education.

Each generation is witnessing an increase in our knowledge on these two vital subjects and the youth of today enjoys better health and better educational facilities than did the preceding generation. Each of these movements is interacting,

better health producing a desire for better education and better education providing better facilities for the maintenance of health. The professions of health and pedagogy therefore go hand in hand and whatever is done for the improvement of the one reacts favorably upon the other. The hospital field has a deep interest in both and is constantly meeting new problems and difficulties in the spread of health and the attainment of education.

With regard to both, it may be said that the ability to teach is the all important factor. The general public and the student of whatever age are not merely empty containers into which knowledge is to be poured and, as a matter of fact, the acquirement of knowledge is not essentially the acquirement of education. A parrot may be taught to speak but it cannot be taught to reason, and unless the ability to reason, that is, to arrive at the unknown from the known, is created, education has not been achieved. Many teachers have acquired knowledge, a few have been educated, but only a small majority can teach.

The true teacher is an amboceptor which can take up knowledge on the one hand and can link it to the mind of the student on the other. Those who have had experience in the teaching field soon learn that students in general take courses for the purpose of getting so many credits, their desire being to put in sufficient time and to learn just enough to pass the examination. With them, education, so-called, is merely a means to a given end and not an end in itself.

If anyone doubts the accuracy of this statement, let him ask a group of his fellows a number of simple questions regarding branches of learning which they studied in grammar school, the high school or the college and he will be amazed at the woeful lack of knowledge displayed. If he will then ask a series of equally simple questions requiring the exercise of reason for their solution, he will be astounded at the scant education the group displays.

The fault may not lie wholly with the student, who may have an earnest desire to improve his mind but may never have been taught how to use it; it may not lie wholly with the teacher, who may have striven earnestly to acquire knowledge but who has never learned how to impart it with inspiration to other people; it may not lie wholly with the educational system which may have been created by well meaning persons with a woeful lack of imagination. Too much of our educational effort is directed to the acquirement of a means of earning a livelihood, that is, the feeding of the body rather than the sustenance of the mind and soul. Perhaps this is at the root of the difficulty.

In the days of ancient Greece pedagogues were slaves and the bulk of the medical work was done by men in a similar social position. Only a few attained to the priesthood of Æsculapius or to the status of one who could teach in the porches. Perhaps it is so even today, perhaps we educators and hygienists are, for the most part, slaves to precedent and convention, only a few of us being permitted by circumstances to enter the sacred groves or to teach upon the temple steps.

A HELPING HAND TO THE SMALL HOSPITAL

A FEW years ago when the people of the smaller towns and rural communities were in need of skilled medical or surgical treatment they were forced, in many instances, to travel three hundred or more miles for hospital care, because their community had a very poor one or no hospital at all.

For the same reason the graduates of medical colleges all over the country have flocked to the cities to practice their profession until today the lack of successors to the passing country doctors is everywhere proclaimed a dilemma.

The recent epidemic of influenza and pneumonia overtaking the capacities of hospitals in many communities has called attention to the acuteness of the problem. Enlarging the bed capacities of city hospitals helps, but it does not solve the problems of providing the much needed hospital facilities in small towns.

A few communities in several of the states have taken the initiative and have built hospitals of which they may well be proud but the great majority of small towns have needed some stimulus to make them realize their duty to public health in this respect. And a stimulus has come with the establishment, March 1, of a Division of Rural Hospitals of the Commonwealth Fund. An initial appropriation of \$350,000 has been made by the Fund for the purpose of building two hospitals in the rural sections of the country each year. The project is presented by H. J. Southmayd, director of the Division of Rural Hospitals, on page 73 of this issue.

The establishment of this fund marks the dawn of the era of small hospitals. No longer will small towns and rural communities have to apologize for their inadequate hospitals, many of which have heretofore been operated for private gain and not for the benefit of the community. These communities now have the opportunity of having efficient hospitals and the more progressive ones will make the most of the opportunity to provide for their sick and for disease prevention work.

The monopoly idea entertained by many large hospitals, namely, that the small hospital is synonymous with inefficiency and that it is doomed to close its doors or be absorbed by the larger institutions, has been exploded, for with the improved roads and methods of transportation the small hospital is no longer isolated or inaccessible. And if the large hospitals have that broader vision of public health and community responsibility they will not ignore the small hospital but will give it a welcoming, helping hand.

LIFEBOATS OR LIGHTHOUSES?

SOME one has said "doctors should not be lifeboats, but lighthouses." No doubt, what this epigrammatist meant to imply was that to save life, after sickness has actually begun, is laudable, but to preserve life, by preventing illness, is better. It would seem that what was said of doctors might with equal force apply to hospitals. Should not hospitals everywhere ask themselves these questions: "Am I a lifeboat or a lighthouse? Am I waiting for the rocks and the tempests of sickness and misfortune to work their fury on men and women, and then often vainly endeavor to stay the hand of death by offering warmth, food and medicine? Or, am I performing the functions of a great warning, yet friendly beacon, that shines cheerily out through the darkness and haze of community ignorance or disregard of the laws of sanitation and right living, pointing the way to the harbor of good health?"

But the hospital may and does perform the function of both the boat that saves, and the beacon that warns. No matter how brilliant the cautioning sign, many there are whose eyes do not perceive the danger of disease, or who have been so caught in the maelstrom of circumstance that sickness comes unannounced and without warning. To these the hospital offers the helping hand of curative medicine, and rightfully so. But even these are often relieved—not cured. Today, more than ever before, the hospital is throwing out into the community its searching beams of scientific truth as to the cause of community ill health, and is effectively using its influence in keeping men, women and children well.

The need for this type of work is more and more claiming the attention of physicians, public health lecturers and hospitals everywhere. No less effectively, but perhaps from a somewhat different motive, great life insurance companies are today entering the field of preventive medicine.

No hospital that has a maternity service feels that it is doing its duty unless it has well-regu-

lated prenatal and postnatal clinics. Certainly, to begin the work of prevention of disease before the child is born is of greatest importance, and to supervise its life during the dangerous first year is even more necessary.

TALKING IT OVER

IN Chicago the system of an hourly nursing service has been organized and is in practice. Hospitals and staffs and superintendents should stand solidly behind this movement if for no other reason than its economic soundness. When a nurse is engaged by the day and is needed only for three hours in which to carry out the attending physician's orders, there is a waste of from five to nine hours of her time that might be devoted to some other case. To people in moderate circumstances this often means that the hospital and physician must both wait for their remuneration longer than if the money were made to go all around. To those who provide for sickness by budget the hourly nursing service means more employment of nurses by the hour, which will result in a quicker return of the patient to production and will be a benefit thereby to society. Hospitals in all parts of the country will watch with interest this organized movement in Chicago.

* * *

A PERUSAL of the administrative section program for the American Hospital Association meeting this month reveals the fact that in common with human beings, hospitals suffer from ills requiring expert attention. A somewhat unique touch is given to this session by the announcement that a clinic on chronic hospital ills is to be held. Perhaps "A Consultation On Institutional Administrative Diseases" would have been a more truly descriptive nomenclature. When the diagnosis of a disease has been determined, then the application of a suitable treatment is much simplified. To have ascertained the cause of trouble, be it in the hospital heating plant or in pounding steam pipes, which robs the patient of his rest, is to point toward the cure.

The successful superintendent finds ample opportunity to exert his skill in the diagnosis, therapeutics and even surgery of hospital administrative diseases.

* * *

DOES there ever come a time when your work palls on you, when the parturition of new thoughts is beset by dystocia and the world is viewed with lacklustre, amarillic eyes? You are not melancholy, the oppressive devil of biliousness is not perching on your shoulder, yet the savor of life has gone and you would welcome as a blessed relief, fire, pestilence or famine. When your symptoms parallel these, there is only one diagnosis—indigestion of the job, and only one treatment—a vacation. You should get as far away as possible from the hospital and all that appertains thereto; friends, foes, family and finance should be forsaken; for the time irresponsibility and the depravity of laziness should be yours. This should be continued until some sad day you find yourself yearning for the job and the old routine. Then you will be cured.

* * *

IF you have ever viewed the moon through the street corner telescope you were probably surprised at the

number of creases and hummocks on the face of the "orbed maiden." Some of us who see only the bumps and creases in our work don't stop to realize that we need a change of lens, that we are viewing our problems through a too high-powered lens, which shows only a detailed segment of the whole.

Vacations often furnish just the needed low-power administrative lens. With rested bodies and rejuvenated minds, hospital men or women, after viewing their problems from their vacation seclusion of mountain or seashore, often find on their return that the problems take on a new aspect and that their solution is surprisingly simple.

* * *

TTEAM work counts. In cities where more than one hospital is found, success for all follows the wholehearted cooperation of every institution. It means the elimination of misunderstanding at all times and the promotion of efficiency, particularly in an emergency. The aims and objectives of all should be the same and are the same if the hospital is worthy of its mission. No differences should be allowed to creep in, no matter how small, because it is from these small beginnings that antagonisms grow. The relations of one institution to another should be of the friendliest kind. The strong should help the weak and all should strive continually to raise the standards of administering to the sick and injured. There is no place for ulterior motives in this work; there is no place for selfishness or intolerance.

* * *

TO most of us in the hospital field forgetting is a vice, an almost unforgivable offense. Where human welfare is at stake, a single lapse of memory may wreak untold harm but in many of our daily experiences may not forgetfulness be a real virtue? Gossip, differences of opinion, irritating behavior, boring conversation, trials that are past, mistakes made, victories won, injustices received—are they not all better forgotten? Memories may be a healing balm or a fox, hidden by the cloak of pride, tearing at our vitals. Can we not be discriminating in our remembering?

* * *

IN the hospital field, every day is the day to make good. The exacting nature of our calling demands that our output shall not be by fits and starts. The curve of our production must not resemble a septic fever chart; its variations must be those of a normal individual. If success is to reward us, ours must be a continuity of useful performance. Perseverance travels farther than fitful dashes.

* * *

"THAT'S a lie," shouted the overwrought golfer as his ball stopped one inch from the hole. How often does the hospital executive feel like exclaiming in similar terms when, after every detail of some institutional matter seemingly has been arranged, the wheels of progress stop dead in their tracks. And yet, even though administrative and financial sand bunkers have been safely crossed, and no intervening waters of personal discord have offered any serious difficulty, to traverse a velvety green to actual accomplishment, seems oftentimes the greatest hazard of all.

To the successful, purposeful hospital director, difficulties in administration add zest to his life. Whether his judgment dictates a bold surmounting or a tactful evasion of institutional hazards, the goal—the better care of the patient—is never out of his sight.

* * *

A "SEVENTEEN HOLER" is a person who never finishes. Usually he is a grand starter; his first shot leaves the tee majestically and he makes his first hole in par; the second is not quite so good; the third shows a let down in performance; the slump is progressive and by the seventeenth hole he has petered out and quit. Every walk of life has its seventeen holers, its unfortunates who never reach destination, its short-lived ineffectives. The hospital field has scant time and no place for these. There is always plenty of room for those who can and will finish the job but for the grand starter and poor finisher, there is no place.

* * *

STATISTICS recently collected and made public by the Federal Government indicate that America expended in the year 1925 more than forty-seven million dollars for chewing gum. The wonderful recrudescence of this habit is unexplainable, therefore, like everything else, it might become a subject of midsummer research.

Whatever may be the cause, gum chewing has taken its place with the saxophone and the jazz band as an instrument of public torture. Flappers now practice for hours each day the gentle art of making their gum snap, and the one who can acquire the most effective staccato tone is adjudged the most accomplished. So wide has been the extension of the habit that the secretary of the navy has, by official order, countenanced the sale of gum on our floating fortresses and the sound of the chonking thereof may well be imagined as resembling the tattoo of a rapid fire barrage silenced only by the reverberations of heavy gun fire. Woe betide us if gum addiction becomes prevalent among hospital personnel! Our nervous patients will be driven into convulsions and many will be the precarious threads of life that will be snapped by the gum snapper. Heaven forbid the entry of this malign masseteric exercise into the peace and quiet of our hospitals and sanatoriums.

* * *

THE story of the life of the sick man in the hospital as recorded on his chart, represents but one chapter in a book that was begun at his birth, and will close at his death. To understand why illness came, often requires a careful perusal of earlier chapters of his life history. Ofttimes there is found inscribed therein a suggestion of comedy, but more frequently, a story of pathos, of human tragedy.

An accurate, logical, well-written ward history is of the greatest importance to the physician, but of equal importance is the story of the past which often only the skill of the medical social worker can procure.

Surely, to presage future chapters in the patient's life, the physician must carefully evaluate and confirm, in the light of the conditions of the present, the facts in the history of the past. Excluding the value of accurate clinical and social deductions to medicine, generally, how priceless are such facts to the patient himself!

NEWS OF THE MONTH

STANDARDIZATION CONFERENCE TO FOCUS ON NURSING PROBLEM AND DEMONSTRATIONS

MORE than two thousand leading surgeons of the United States and Canada besides a large representation from hospitals and the nursing profession are expected to attend the annual hospital standardization conference of the American College of Surgeons, to be held at the Hotel Windsor, Montreal, October 25-29. This is the first time that an opportunity has been extended for the three groups primarily interested in the welfare

strations to be carried out in the various Montreal hospitals.

The tentative program for the four-day conference follows:

Monday Morning, October 25, 9:30-12:30

R. Matas, M.D., New Orleans, President, Presiding
Chairman's remarks.

Address—The Montreal Hospitals.

Address—The Montreal Hospital Council.

Presentation of the hospital standardization report for 1926.

Paper—The Minimum Standard as a Factor for Better Surgery.

Paper—The Minimum Standard as Applied to the Department of Internal Medicine.

Paper—Educational Opportunities of Hospital Standardization.

Paper—The Trustee's Responsibility in Hospital Standardization.

Paper—Hospital Standardization from a New Zealander's Viewpoint.

General discussion.

Afternoon Session, 2-5

Symposium—The Trend of Nursing Standards, Education, and Service in Hospitals Today.

- (a) From the Standpoint of the Medical Profession.
- (b) From the Standpoint of the Hospital.
- (c) From the Standpoint of the Nursing Profession.

Round table conference and general discussion.

Tuesday Morning, October 26, 9:30-12:30

W. W. Chipman, M.D., Montreal, President-elect, Presiding
Chairman's remarks.

Paper—Some Things Which Seem to be Lacking in Hospitals.

Paper—Special Problems and Their Solution from a Survey of the Hospital Field.

Round table conference.

Topics for discussion:

- (a) The Importance of Strict Operating Room Control.
- (b) A Successful Method of Analyzing Hospital Deaths.
- (c) An Annual Medical Audit for Hospitals.
- (d) Open versus Closed Hospitals.
- (e) Basic Considerations and Requirements for
 - (1) Extension of Privileges to Doctors to Attend Private Patients in Hospitals.
 - (2) Membership and Appointment to the Attending Staff.
- (f) Staff Organization in the Various Types of Hospitals.
- (g) The Proper Conduct of the Staff Conference.



Dr. A. K. Haywood, chairman, Montreal Hospital Council, Montreal, and superintendent, Montreal General Hospital.

of patients to meet on such a large scale and, according to Dr. A. K. Haywood, superintendent, Montreal General Hospital, chairman of the recently formed Montreal Hospital Council, every effort is being made so that out of the conference may come a solution for the various conflicting viewpoints held regarding nursing standards, nursing education and the present trend of nursing service.

In addition to round tables and symposiums on practice problems one of the attractive features of the conference this year will be a series of practical studies and demon-

- (h) Follow-up and End Results in hospital work.

Afternoon Session, 2-5

Symposium—A Minimum Standard for Hospitals in the Care of the Industrially Injured or Ill, coming under the Provisions of Workmen's Compensation Laws.

- (a) Workmen's Compensation Laws, Their Intent and Significance.
- (b) Ambulance Service and First Aid.
- (c) Hospital Reception of Injured Workmen.
- (d) General and Special Features in Hospitals for Adequate Treatment of Industrial Patients.
- (e) The Essentials for a Complete Hospital Record of Industrial Patients.
- (f) Cooperation between the Hospital and Those Administering Workmen's Compensation Laws.
- (g) The Care of the Ambulatory Patient and the Follow-up of Discharged Hospital Patients.

Round table conference and general discussion.

Wednesday, October 27, 10-12:30, 2-4:30

Demonstrations.

Montreal General Hospital—central division.

Organization and management of an out-patient department.

Organization and management of a metabolism department in a general hospital.

Essential requirements for fracture ward and splint room.

Organization and management of a record room.

Special features as seen in the new teaching unit of the school for nurses.

Organization, management, and functioning of the general office and purchasing department.

Notre Dame Hospital.

Demonstration of model small ward unit and operating room department.

Ste. Justine Hospital Pour Les Enfants.

Special features of a modern children's hospital.

Alexandra Hospital.

Demonstration of the cubicle system in the treatment of contagious diseases.

Montreal General Hospital—western division.

Demonstration of a model x-ray department for a small hospital.

Thursday, October 28, 10-12:30, 2-4:30

Royal Victoria Hospital.

Detailed study of the new maternity hospital—planning, construction, equipment and organization.

Demonstration of model diabetic and dietary service.

Study of a model general operating suite and service. Demonstration of equipment and management of physiotherapy department.

Demonstration of model otolaryngological department.

Shriner's Hospital.

Study of a model orthopedic hospital—planning, construction, equipment, organization, and procedures.

Hotel Dieu Hospital.

Demonstration of a model record room.

Demonstration of a hospital pharmacy.

Hospital Francais de Montreal.

Demonstration of a model operating room.

Children's Memorial Hospital.

Study of a children's hospital with its special features and school for crippled children.

ONTARIO PLANS HEALTH CENTERS

The equipment of all general hospitals of the province of Ontario as health centers for the prevention of disease is the object of the plans for the promotion of this work discussed at a joint meeting of the board of directors and the legislative committee of the Ontario Hospitals Association recently.

COLORADO ASSOCIATION TO MEET SEPTEMBER 21-22

According to Edgar A. Bocock, executive secretary, the Colorado Hospital Association, at its second quarterly meeting, July 12, at the St. Joseph's Hospital, Denver, decided to hold its annual meeting September 21-22, at Colorado Springs, in conjunction with the Colorado Medical Society. The tentative program includes addresses by several prominent leaders in the hospital field who will conduct round tables.

The quarterly meeting was attended by representatives of twenty-seven institutions throughout Colorado, who appointed delegates to the American Hospital Association convention to be held in Atlantic City. It was also announced that the association had established a personnel bureau and a service bureau which are available to all members of the organization for the solution of their administrative problems, such as the procuring of help.

Following the conclusion of the business meeting Father Joseph Higgins, Pueblo, spoke upon "The Benefit of Publicity in Hospital Administration." He stressed the necessity for the public to know the expenditures made annually for hospital administration, since the citizens and tax payers are largely unfamiliar with hospital costs.



Colorado General Hospital, Denver.

Personals

DR. LEWIS M. WALKER, director, U. S. Veterans' Hospital, Fort Roots, Ark., has been transferred to U. S. Veterans' Hospital No. 62, Augusta, Ga. He will be succeeded by DR. FREDERICK R. SIMS, who has been clinical director at the Augusta hospital.

ANNA FREIDSBURG, superintendent, old Midway Hospital, has been appointed superintendent, new Midway Hospital, St. Paul, Minn., according to a recent announcement of the board of directors of the hospital. The new hospital was recently opened.

GUSTAV S. ROTH, president, United Israel Zion Hospital, Brooklyn, N. Y., recently appointed a special committee in charge of the building of the new four-story wing to that institution, which will increase the total bed capacity 25 per cent.

CHARLES F. NEERGAARD, consultant, New York, has been retained by the Quakertown Hospital Association, Quakertown, Pa., as consultant for the new community hospital which will have a capacity of fifty beds.

CLARA SCHAFER, superintendent, South Chicago Community Hospital, Chicago, was the guest of honor at a recent banquet given by the board of directors of the hospital in recognition of her six years of service.

JOHN WELZ, president, Wyckoff Heights Hospital, Brooklyn, N. Y., recently returned to this country following a three months' visit of institutions in France and Germany.

DR. S. B. HERTZOG, former member of the staff of the State Tuberculosis Sanitarium, Hamburg, Pa., has been appointed superintendent of the Neversink Mountain Tuberculosis Sanitarium, Reading.

MINNIE HAYDEN, who recently resigned as superintendent of the Jackson Park Sanitarium, Chicago, after twenty-five years of service, was the guest of honor at a tea given July 7. MRS. ELIZABETH PAULIG has been appointed new superintendent of the institution.

RUTH E. ROBERTSON is superintendent of the new Kennedy Deaconess Hospital, Havre, Mont., which opened in July.

DR. D. R. NAGEN recently purchased the Sumas Hospital, Sumas, Wash., from MRS. E. S. CLARK.

THOMAS T. MURRAY has commenced his duties as superintendent of the Albany Memorial Hospital, Albany, N. Y., succeeding SARAH PALMER, resigned. He was formerly superintendent of the Knoxville General Hospital, Knoxville, Tenn.

MRS. A. J. MCARTHUR is superintendent of the new North Park Maternity Hospital, Broken Bow, Nebr., which was recently opened.

DR. WILLIAM MARMADUKE BROWN has been appointed physician in charge of the new Shriner Hospital for Crippled Children, Lexington, Ky., which is rapidly nearing completion.

BRIG. GEN. JAMES M. KENNEDY, U. S. A., recently as-

sumed his duties as commanding officer of the Walter Reed General Hospital, Washington, D. C.

MRS. DAISY C. KINGSTON, superintendent, Somerset Hospital, Somerville, N. J., recently announced that a total of 1,024 days' treatment was given in the hospital during the month of June with an income of \$7,502 and an expense of \$6,631.95.

JOHN H. MAUNEY was recently named superintendent, Knoxville General Hospital, Knoxville, Tenn., by T. K. Haynes, director of public welfare. He fills the position left vacant by the resignation of T. T. MURRAY, former superintendent.

DR. BERTRAND B. JAFFA has been appointed assistant superintendent, Denver General Hospital, Denver, Colo., succeeding DR. ETHEL D. HUMPHRYS, resigned.

CLARA DIENST, former superintendent of nurses, Lutheran Sanitarium, Hot Springs, S. D., was recently appointed superintendent of the Lutheran Deaconess Hospital, Beaver Dam, Wis.

DR. T. B. BASS, superintendent, State Epileptic Colony, Abilene, Tex., was recently elected second vice-president of the National Psychiatric Association.

FRANCES CHAPPELL, for eleven years superintendent, St. Luke's Hospital, St. Louis, was recently named superintendent of the Methodist Hospital, Guthrie, Okla. DR. C. A. LARKIN, former superintendent, resigned to enter private practice.

DR. C. H. CABLE, superintendent, Elmwood Sanitarium, Bushnell, Ill., recently tendered his resignation to take effect October 1.

DR. D. W. BLACK, Salt Lake City, Utah, was recently appointed to succeed DR. E. O. CROSSMAN, as medical director, U. S. Veterans' Bureau, according to an announcement by General Frank T. Hines, director of the bureau, Washington, D. C. Dr. Crossman resigned to accept an assignment as medical officer in charge of the veterans' hospital, West Roxbury, Mass.

MRS. NORA CLARK, superintendent, Chillicothe Hospital, Chillicothe, Mo., recently completed arrangements for the purchase of the equipment of the New Hospital, Chillicothe.

A. WINIFRED GOLLEY has been appointed superintendent, new Centralia General Hospital, Centralia, Wash., which was recently opened to the public.

DR. LENA V. INGRAHAM, one of the founders of the Vincent Memorial Hospital, Boston, died recently in that city. Dr. Ingraham had been a practicing physician since 1888 and was senior surgeon at the hospital from 1890 to 1898.

KATHERYN POND, formerly superintendent, John McDonald Hospital, Monticello, Iowa, has been named superintendent of the Burge Hospital, Springfield, Mo., succeeding GRACE BARR, R.N., resigned.

DR. H. L. GOODMAN, formerly superintendent, McKendree Hospital, McKendree, W. Va., and DR. W. L. VAN SANT, physician in charge, Hinton Hospital, Hinton, recently purchased Dr. Love's Private Hospital, Ronceverte.

DR. JOHN N. THOMAS, superintendent, Central Louisiana State Hospital, Pineville, La., recently completed forty years of service to the state in various capacities.

O. N. RIGGS, who has been superintendent, Monongalia County Hospital, Morgantown, W. Va., for the past three years, recently resigned.

W. CRANE LYON, superintendent, Mercer Hospital, Trenton, N. J., for the past three years, recently resigned to become associated with Charles F. Neergaard, hospital consultant, New York.

ELLA RICHARDSON, assistant superintendent, Lowell General Hospital, Lowell, Mass., recently was appointed superintendent, Knox County General Hospital, Rockland, Maine, succeeding GRACE L. WOLCOTT, resigned.

DR. S. A. SLATER was recently reappointed superintendent, the Southwestern Minnesota Sanatorium, Worthington, Minn.

DR. GEORGE SARTWELL was recently appointed head, Rhode Island State Infirmary for Mental Diseases.

DR. WILLIAM S. FAST, superintendent, Nebraska State Hospital, Ingleside, Neb., died June 27. DR. G. M. WHITE has been appointed acting superintendent.

ELSIE CREMEENS is in charge of the new Dr. Cullers Bungalow Hospital, Trenton, Mo., which was recently opened to the public.

DR. L. O. DAVENPORT has been appointed superintendent, Jefferson Tuberculosis Sanatorium, Birmingham, Ala., to succeed DR. W. H. CRYER, deceased. Dr. Davenport was formerly connected with the Union Printers' Home and Tuberculosis Sanatorium, Colorado Springs, Colo.

IDA B. VENNER, superintendent, Passavant Hospital, Jacksonville, Ill., for the past sixteen years, recently tendered her resignation to the board of trustees of the hospital.

IRIS OGLE was recently appointed assistant superintendent, State Tuberculosis Sanitarium, Springfield, Ill.

MRS. GRACE HENGVELD is the superintendent of the new baby hospital which recently opened in the Northampton-Accomac Memorial Hospital building, Nassawadox, Pa.

KATHERINE M. YATTAW has been appointed superintendent of nurses, Floating Hospital, New York.

DR. ASA BRUNSON is physician in charge of the new Tuberculosis Sanatorium, El Paso, Tex. P. S. BOUTET has been retained as superintendent of the institution.

DR. A. H. HARRINGTON, superintendent, State Hospital for Mental Diseases, Howard, R. I., for the past nineteen years, recently resigned from that position.

DENA GRONEWOLD, R.N., was recently appointed superintendent of the new Newton Memorial Hospital, Topeka, Kan. Miss Gronewold was formerly superintendent, McPherson County Hospital, McPherson.

CHICAGO ORGANIZES HOURLY NURSING SERVICE

A luncheon was given at the Chicago Women's Athletic Club, 606 South Michigan Boulevard, Chicago, on July 21, for the purpose of discussing plans for the hourly nursing service that has been organized and initiated in that city.

Mrs. Perkins B. Bass, Evanston, Ill., presided, and expressions of opinion on the subject were given by practically all of the forty-three people present. Dr. Morris Fishbein, editor, *Journal of the American Medical Association*;

Dr. R. R. Ferguson, president, Chicago Medical Society; Dr. M. T. MacEachern, director of hospital activities, American College of Surgeons; Edna L. Foley, R. N., superintendent, Chicago Visiting Nurse Association; Mrs. Theodore Teakin, Committee on Hourly Nursing; Minnie Ahrens, secretary, First District, Illinois State Association of Graduate Nurses, Chicago; Mrs. J. L. Patten, Evanston, Ill., Dr. Frank L. Rector, editor, the *Nation's Health*, and others, contributed ideas toward the project.

A committee on publicity for hourly nursing was formed and met on Monday, July 26. The committee was composed of Mrs. Teakin, Mrs. Bass, Mrs. Ernest Irons, May Watson, superintendent of nurses, Grant Hospital, Chicago; Evelyn Wood, Central Council for Nursing Education; Minnie Ahrens, Mrs. John Walker, Carroll Binder, *Chicago Daily News*; Dr. Fishbein and John A. McNamara, managing editor, *THE MODERN HOSPITAL*. The next meeting of this committee will be held in September.

COURSE IN HOSPITAL ADMINISTRATION TO BEGIN OCTOBER 7

The enrollment in the 1926 summer course in hospital and institutional management at Temple University, Philadelphia, shows that there is a widespread interest on the part of hospital executives in increasing their efficiency through intensive study.

It is interesting to note that only 50 per cent of the enrollment is from the State of Pennsylvania, while the remaining 50 per cent is from California, Michigan, New York, Massachusetts and New Jersey.

The positions held by the members enrolled are those of superintendents of general hospitals, superintendent in Indian service, superintendent of an orphanage, directress of nurses, instructresses of nurses, hospital supervisor and nurse in charge.

Enrollments have already been received for the winter course which will begin October 7, 1926, and will be given each Thursday evening from 7:30 to 9:30, for thirty weeks. Charles S. Pitcher, superintendent, Presbyterian Hospital in Philadelphia, who has directed the course for the last three years, will again have general supervision and will be assisted by the same lecturers who conducted classes last winter.

The Sixth Edition of *THE MODERN HOSPITAL Year Book*, Weber's *First Steps in Organizing a Hospital*, and Chapman's *Hospital Organization and Operation* are among the textbooks used. In addition to these, a number of other books, comprising both foreign and American publications, are used by the class.

DR. CORWIN STUDIES EUROPEAN HOSPITAL METHODS

Dr. E. H. Lewinski-Corwin, director, Hospital Information Bureau of the United Hospital Fund and executive secretary of the Committee on Public Health Relations of the New York Academy of Medicine, New York, is now in Europe where he went to address the joint session of the German and Austrian hospital associations in Vienna.

Foreign interest in the progress of American hospitals led to the invitation to Dr. Corwin, whose work with the United Hospital Fund and the Academy of Medicine makes him especially fitted to discuss his subject, "The Evolution of the American Hospitals and Present-Day Hospital Problems."

While abroad Dr. Corwin will visit many German, Austrian and Swiss hospitals, where he will study European methods.

ADVANCES IN NUTRITION, FINANCE AND PERSONNEL TO BE DISCUSSED AT DIETETIC MEETING

FINANCING the hospital and its direct influence on the dietary department will be one of the important subjects that will be given a prominent place on the program of the ninth annual meeting of the American Dietetic Association, to be held at the Ambassador Hotel, Atlantic City, N. J., October 11, 12 and 13.

As has been the custom in former years, an interesting exhibit has been planned together with a number of trips, both professional and non-professional. The hotel and railroad rates are such that it will be possible to combine an Atlantic City vacation with a three-day intensive study of the progress of dietetics and allied professions all at a reasonable cost. Because of the proximity of New York, Philadelphia, Baltimore and Washington, with their medical and hospital facilities and points of interest, side trips have been planned with a local person in each city in charge of the sight seeing trip. Motor trips to Annapolis and other points along the shore have also been planned.

Social Aspects Given Special Attention

This year especial attention has been given to the social aspects of the meeting. On Monday, October 11, a get-together luncheon will be held at which achievements of members of the association will be presented. On Tuesday a round table luncheon is scheduled at which time pertinent questions will be discussed, among them such subjects as the pay cafeteria; per capita costs; standardized recipes; new equipment and new utensils; correlation of theoretical and practical work for the student nurse; teaching the medical student; methods of planning and calculating special diets; the training of the dietitian in the out-patient department; types of commercial opportunities; the consulting dietitian, and the renaming of the social service section.

The first session, which will be held Monday at 9 a. m., includes the presidential address, by Dr. Ruth Wheeler, professor of nutrition, Vassar College, Poughkeepsie, N. Y., and three papers of unusual interest to members of the profession. They are "General Financial Problems in the Endowed and Municipal Hospital," "The Role of the Dietitian in Planning the New Hospital," and "The Hospital From a Business Standpoint."

At 2 p. m. a business meeting will be held, followed by tea at 4:30.

The evening session, at 6 o'clock, will be in the form of a banquet general session, with Dr. Ruth Wheeler presiding. The subject of the evening will be "Advancement in the Basic Sciences," and the topic will be discussed from the standpoints of physiology, chemistry and economics. Dr. J. J. R. Macleod, University of Toronto, Toronto, Ont., who took an active part in the discovery of the insulin treatment of diabetes, will tell of the advances in physiology; Dr. Julius Stieglitz, University of Chicago, Chicago, will talk on the changes in chemistry, and a well-known person in the field of economics, to be announced later, will discuss the economic advances.

The administrative section to be held Tuesday at 9:30 a. m., with Elva George, dietitian, Municipal Public Welfare, New York, presiding, will be devoted to such phases of dietetics as food budgeting of the dietary department equipment; cooked food standards, how to establish and how to maintain them, and the report of the committee on the food budget form and its use.

Following the luncheon at 12 m., a general session, with Octavia Hall Smiley, dietitian, New York, presiding, will be held at 2:30 p. m. The topics for discussion at this session are those of particular interest to the general public, such as teeth and diet; our present knowledge of rickets; diabetes in children, and vitamin B in the general health problem.

The general session to be held at 8 p. m., under the chairmanship of Lulu G. Graves, consultant dietitian, New York, will be devoted to the general subject of management of personnel. At this time Dr. A. F. Payne, department of industrial relations, New York, is scheduled to speak on personnel management.

The education and social service sections will be held Wednesday morning, the former at 9:30, under the chairmanship of Eva Thallman, dietitian, Massachusetts General Hospital, Boston, and the latter at 10, under the chairmanship of Rachael Sanders, dietitian, Chicago.

Nutrition in the nursery school and nutrition in the health clinic are the subjects to be discussed at the social service section.

Dietotherapy is the theme of the papers to be presented at the therapeutic section, Wednesday at 2:30. "High Protein Diet Without Meat, in Nephrosis," is the subject of the paper to be presented by Fairfax Proudfit, consulting dietitian, Nashville, Tenn. This will be followed by a paper, "Protein Utilization in Skeletal Tuberculosis," by Elizabeth Wittacker, dietitian, Michigan State Agricultural College, East Lansing, Mich., and one on "Specific Dynamic Action of Protein in Obesity," by Mary Harrington, dietitian, University of Michigan Hospital, Ann Arbor. Martha Davis, dietitian, Scripps Metabolic Clinic, La Jolla, Calif., will speak on the subject of "Some Studies of Protein in Hyperthyroidism." The session will conclude with a paper, "Protein Requirement in Children," the speaker to be announced later.

At 8 p. m. a general session, under the chairmanship of Mary de Garmo Bryan, dietitian, New York, will be given over to a survey of nutrition.

JOHN E. RANSOM ACCEPTS POSITION AS TOLEDO SUPERINTENDENT

John E. Ransom, who was director, Michael Reese Dispensary, Chicago, for five years, recently accepted the position of superintendent, Toledo Hospital, Toledo, Ohio, and has assumed management of that institution. He acted as executive secretary, American Hospital Association, following the death of Dr. A. R. Warner, until the appointment of Dr. William H. Walsh as executive secretary. Mr. Ransom also served as consultant in health administration in various parts of the country and last year made a survey of the medical needs and problems in the juvenile courts of Cook County, Illinois.

Although he obtained the highest mark in the recent civil service examination for the newly created post of director of the Cook County Bureau of Public Welfare, Mr. Ransom chose to continue his work in the hospital field and assumed his duties as superintendent of Toledo Hospital.

He will be in active charge of the recently confirmed building program at that institution, which will include the construction of new buildings and the expansion of its present capacity to 250 beds.

THE OPEN FORUM

Thoughts, opinions and criticisms are invited for these pages from readers in all departments of hospitals and related services. Please address letters and other communications to the Editor, THE OPEN FORUM.

WHAT IS A MAJOR OPERATION?

PERHAPS no term in medical and hospital usage is subjected to more diversified concepts than is the expression, major, or minor as the case may be, operation. A few years ago there seemed to prevail an unwritten understanding among a great number of surgeons that all operations requiring a general anesthetic automatically became major. But today when more and more serious operations are being performed with the use of local anesthesia, this method of judging no longer obtains.

For ordinary purposes it would seem that the gravity of the operation and the risk entailed to the patient would constitute the basis for differentiation. However, the term as now used connotes widely diversified conditions according to local usage and the point of view, as will be noted from the varieties of opinion expressed by more than a score of hospital superintendents.

**S. S. GOLDWATER, M.D., Director,
Mount Sinai Hospital, New York:**

"A major operation is a severe or serious operation, not a slight or trivial one, but from comparatively trivial surgical procedures serious consequences sometimes result. The test lies in the gravity of the operation, which must be gauged not merely by the technical difficulty of the procedure, but by the risk to the patient; and in using the term risk I am thinking not only of the risk to life, but of the likelihood that any important bodily function may be impaired.

"Elements to be considered are: the scope of the surgical procedure; the danger of shock; the presence of known complications, which add to the risk the probability or possibility of unsuspected pre-existing surgical complications; the probability or possibility of postoperative complications; the probable duration of the operation; the age and general condition of the patient (presence of intercurrent disease, not directly related to the operation); the degree of mutilation; the amount of pain or mental anguish caused; the nature of the anesthetic used, and the risk of legal complications in the case of an unsuccessful result.

"It will not do, for example, to say that a tonsillectomy is a minor operation; it might well be this in the case of a healthy child, and especially if the operation were performed without a general anesthetic. It would scarcely be so in the case of a complete tonsillectomy performed

under anesthesia on a person of advanced years (as many a sufferer will testify). But even the most hopeful form of tonsillectomy, in the most promising type of patient, can result (and occasionally does result) in lung abscess. Similarly, the removal of hemorrhoids may properly be classified as either a minor or major operation, according to the circumstances. Moreover, the very slightest surgical interference, if performed without due regard to asepsis, obviously involves a risk out of proportion to the ordinary rating of the procedure."

**MALCOLM T. MacEACHERN, M.D., Associate Director,
Am. College of Surgeons, Hospital Activities, Chicago:**

"The best definition or explanation that we have in our possession for a major operation is that which we received from the American Medical Association which states that a major operation is a surgical procedure that entails immediate serious consequences to the patient and requires skill and training to perform.

"The definition includes (1) The setting of fractures of long bones and reducing of subluxations, providing accuracy and efficiency of reduction be demonstrated by roentgen ray taken before and after surgical treatment, and (2) all operative procedures, other than finger and toe amputations, cleansing, draining and closing wounds, evacuating pus by incisions, the manipulating and reduction of uncomplicated dislocations, the treatment of uncomplicated fractured ribs, the removal of superficial foreign bodies from the eyes, and the removal of subcutaneous foreign bodies."

**JOSEPH C. DOANE, M.D., Medical Director,
Philadelphia General Hospital, Philadelphia:**

"The term 'major surgery' is one that is usually applied to the more difficult and dangerous procedures. But since one is dealing largely with comparatives, in speaking of a major or a minor work or step, we can draw no fine line of distinction between a greater and a lesser operation.

"Does one use the term major operation because such a step is more difficult for the surgeon, of greater length or tediousness, of more danger, or of greater ultimate benefit to the patient?

"Every operation is a major procedure to most patients. To those of a nervous makeup, the mere incision of a boil is of great importance. To the young surgeon a step, which to his chief might appear trifling, assumes the dimensions of a very major operation, indeed. Even the most simple surgical step may be complicated by most serious after effects. Nor can the extent of tissue disturbed be a trustworthy criterion to point toward a proper classification. The removal of a huge surface tumor, weighing several pounds, may invoke but ordinary skill

and training, while the excision of a cataract disturbs but little tissue, although it is an operation that requires much skill and experience.

"If major and minor are to become surgical terms at all accurately descriptive of a certain group of operations, then such facts as the skill of surgeons, the preoperative condition of patients, and the technique used must approach a constant rather than a variable quantity. Until then only a truly local interpretation can be given, unless an arbitrary list of operations, usually fraught with danger to the patient, can be compiled and generally accepted, as best described by the term major."

**R. G. BRODRICK, M.D., Director of Hospitals,
Alameda County Hospital, San Leandro, Calif.:**

"Dorland defines a major operation as being one that places the patient's life in jeopardy.

"An operation which a few years ago might have involved a serious hazard to the patient now, with our vastly increased knowledge of pathology, anatomy, and the results which can be obtained, becomes a simple procedure and may be considered minor by skilled surgeons.

"An operation that might be classed by an experienced surgeon as a minor procedure, becomes a serious undertaking in the hands of an inexperienced surgeon.

"Operations that ordinarily are considered minor, may become major procedures on account of some existing pathological condition, such as infection or carcinoma, for example, which might produce a hazard to life or health through the spread of that condition.

"In general, a major operation may be defined as one in which any body cavity is opened, in the performance of which, or because of some existing pathological condition, life is placed in jeopardy; or one in which the procedure requires especial training or skill for its successful accomplishment."

**LOUIS H. BURLINGHAM, M.D., Superintendent,
Barnes Hospital, St. Louis, Mo.**

"I recognize that for various reasons it is desirable to distinguish between the less severe and the more severe operations. The use of the terms major and minor, however, has never been satisfactory, in my opinion. I should think that it might be well to classify all those procedures as major operations which require a patient to stay in bed for more than twenty-four hours after the operation. The other operations could be considered minor. Even such a classification as this, however, is not at all satisfactory, but I cannot think of any better distinction."

**NATHANIEL W. FAXON, M.D., Director,
Strong Memorial Hospital, Rochester, N. Y.:**

"The question, what is a major operation, is one of those academic questions about which there can seldom be any exact agreement. It is not only complicated by the divergence of opinions of surgeons, but also by the human factor of the patient. What is a minor operation to one patient becomes a major operation to another. The age of a person makes such a vast difference in surgical risks that again, the minor operation of a robust man of twenty-five becomes a major operation for the man of seventy.

"The type of surgery that can be carried on in a physician's office or in the home or in an out-patient department, which leaves the patient ambulatory immediately after operation or within a short time may be considered as a minor operation.

"Any operation that requires a general anesthesia of more than fifteen minutes' duration should be regarded

as a serious operation, in that the risk to the patient is as great as in some more distinctly major procedures. Wherever a general anesthesia is given, it is probably wiser always to hospitalize the patient as a matter of precaution. This naturally would include tonsillectomies, removal of adenoids and circumcision.

"From the pathological standpoint, one might class as minor surgery the less serious everyday problems of surgical practice—simple inflammations, infections and injuries including some fractures and benign tumors that are easily accessible. Many infections of the hand, formerly regarded as minor surgery and treated as such are now considered as important major procedures because of the economic value of a functioning hand.

"I think the most important factors in defining minor and major surgery are: Whether the patient remains ambulatory; whether a general anaesthetic has been given, and the risk for the patient.

**JOSEPH B. HOWLAND, M.D., Superintendent,
Peter Bent Brigham Hospital, Boston, Mass.**

"A surgical diagnosis textbook describes a major operation as that which is concerned with the more important and dangerous operations, and minor operations as those which are concerned with the less formidable operations, such as bandaging and application of splints, etc.

"I do not think these definitions are sufficiently enlightening for the purposes of hospital executives. Major operations are certainly those which would be considered the more important and dangerous operations. I would include for our purposes any operation covering a considerable period of time, or one using an appreciable amount of surgical supplies. Likewise, a minor operation might be considered one requiring little or no assistance, brief anesthesia, either general or local.

An example of an operation which might, from its name, be in either class, would be that of an incision of a septic hand. It might be a prolonged operation of serious consequence, and requiring the highest skill or, on the other hand, it might be of the simplest nature.

"I should say that the classification as to whether a given case is a major or minor operation will frequently have to be made by the surgeon after the operation is finished."

**LEWIS A. SEXTON, M.D. Superintendent,
Hartford Hospital, Hartford, Conn.:**

"Twenty years ago the generally accepted differentiation between a major and a minor operation was very simple. Any operation requiring a general anesthetic was major and all others of whatever nature were minor.

"Surgery has kept its place in the world's advancement, and today there is not an operation known to the profession that may not be done under local anesthesia. This condition renders obsolete all former classifications, and makes difficult, if not impossible, any such differentiation.

"It seems to us that if for any reason operations must be classified, this classification must be based on the seriousness of the operation, the risk to which the patient is subjected and the amount of total disability entailed.

"It is our opinion that any operation, no matter what the type or character may be, entails a certain element of risk to the patient, and that operations should not at any time be regarded as minor procedures.

"Aside from the surgical procedure, operations are classified by underwriters for purposes of adjustment. These classifications, however, are necessarily arbitrary, and vary according to the interpretation of the different companies. I have asked three of our large insurance

companies to define a major and a minor operation. Their definitions are: (1) A major or capital operation is one that seriously endangers the life or faculties of the patient; (2) a major operation is one which, of necessity, entails a variable period of total disability, the average of which exceeds two weeks; (3) from an underwriter's viewpoint, a major operation is any operation that may effect the longevity of the patient."

H. K. MOHLER, M.D., Medical Director,
Jefferson Hospital, Philadelphia:

"From the surgeon's point of view an operation may be major, but from the hospital's point of view, especially with regard to fixing the operating room fee, the same operation may be considered a minor one, this view being based on the short time required for the operation, the fact that no general anesthetic was administered, few assistants and practically a minimum amount of operating supplies were used.

"An operation may be a minor one from the surgeon's point of view in that no immediate serious consequences are entailed, but from the hospital's angle in determining the charge, the operation may be considered a major one in that many assistants, the use of the operating room for several hours, and expensive medicines and supplies may be needed.

"I am enclosing a copy of the definition of a major surgical operation as ruled by the Pennsylvania Workmen's Compensation Board prior to 1919, at which time the compensation to the surgeon and the hospital depended upon whether a major or a minor operation was performed.

"The Pennsylvania Workmen's Compensation Board defines a major operation as a surgical procedure that entails immediate serious consequences to the patient and requires skill and training to perform.

"It includes (1) The setting of fractures of long bones and reducing subluxations, provided that accuracy and efficiency of reduction be demonstrated by x-ray before and after surgical treatment, and (2) all operative procedures, other than finger and toe amputations, cleansing, draining and closing wounds, evacuating pus by incisions, the manipulating and reduction of uncomplicated dislocations, the treatment of uncomplicated fractured ribs, the removal of superficial foreign bodies from the eyes and the removal of subcutaneous foreign bodies."

H. A. HAYNES, M.D., Director,
University Hospital, Ann Arbor, Mich.:

"In general a major operation may be described as one which carries a notable risk to life. I think that a two per cent mortality should be regarded as notable. Clearly the structure operated upon or the nature of the operation cannot be relied upon to decide the question of whether an operation is major or minor. The other factors that must be taken into consideration are the condition of the patient in other respects, his age and resistance, and the skill and dexterity of the surgeon.

"Thus, an operation for inguinal hernia should not ordinarily be regarded as a major operation, but undertaken upon a patient in poor general condition, in advanced life, or by an unskilled surgeon, it should certainly be classified as major.

"An appendectomy may often be a minor operation, while at other times it is certainly a major one.

"Under ordinary conditions cystoscopy and catheterization of the ureters, if regarded as an operation at all, is regarded as a minor one, yet patients have died as a consequence of this procedure. There are certainly cases

of patients in poor condition in which cystoscopy with catheterization, if justifiable at all, should be regarded as a major operation. The risk rather than the operation itself, I think, is the only sound criterion."

R. H. OPPENHEIMER, M.D., Superintendent,
Wesley Memorial Hospital, Emory University, Ga.:

"The term major operation depends entirely upon the individual idea and more or less empirical rulings. For practical working purposes an almost separate classification is necessary. The line of division into major and minor operations in this hospital and quite generally in this community is based primarily upon two factors, the magnitude of operative procedure and the danger met with in the operation. Thus, we classify as minor operations tonsillectomies, removal of cataracts, submucous resections, incision of ordinary abscesses, excision of lipomas and similar benign superficial tumor masses, while all laparotomies, amputations and large orthopedic procedures are classified as major operations.

"In general, the division is one that has in it the element of time and effort consumed, assistance in the adjustment of the operating room and anesthesia charges.

"I feel that any operation requiring general anesthetic, the use of morphine and scopolamine, together or alone, or the use of more than a minimum of novocaine or cocaine should be a major operation. I would include in this classification blood transfusions, and therapeutic spinal punctures and cistern punctures."

A. K. HAYWOOD, M.D., Superintendent,
Montreal General Hospital, Montreal:

"Dr. A. T. Bazin, chief of surgical staff, gives the following description of a major operation:

"In the bare essentials the dictionary definition suffices, namely, that a major operation is a surgical procedure that involves risk of life.

"But risk of life depends not alone upon the magnitude or delicacy of the procedure but upon the condition, apparent or concealed, of the patient. A simple circumcision in an infant could never be considered a major operation, but, the risk to life in a bleeder would be very great. Then, again, the duration of an operation, the amount of blood loss, the depth of shock induced, all have much to do with the risk to life and these in any stated operation vary with the skill and technique of the individual surgeon.

"We are forced then to amplify the dictionary definition and state that a major operation is a surgical procedure which, under the existing conditions of patient, environment and attendants, involves risk of life.

"From an administrative point of view and to determine costs, a major operation could be classed as one demanding prolonged duration, abundance of material and equipment and a full staff of operating room personnel."

HERMAN SMITH, M.D., Superintendent,
Michael Reese Hospital, Chicago:

"I imagine the question comes up because of the varying fees for so-called major operations. In our organization we side-step the question entirely by charging the same fee for all operations performed in the operating room. Outside patients may be brought to our emergency dressing room for so-called minor operations, and for these patients, a smaller charge is instituted. Our method of charging I do not believe is entirely fair because an in-patient would have to be brought to the operating room and charged a regular operating fee for the same type of work an outpatient might have done in the emergency dressing room for a very much smaller fee.

"The type of work done in the emergency dressing room is that which can be handled by the one supervising nurse in charge of this room. If she cannot handle the situation alone, she would not allow the procedure to be started in the emergency dressing room but would refer the surgeon to the main operating room.

"I think that each particular hospital has to decide for itself the charges for the various types of work and its policy of regarding places in which this work may be done."

W. L. BABCOCK, M.D., Director,
Grace Hospital, Detroit, Mich.:

"What is a major operation is a question that we would like to have defined. Prior to the days of local anesthesia in major operations, such as hernias, abdominal sections, the line was crudely drawn between major and minor operations by the general anesthetic. Major operations were then considered as those requiring a general anesthetic, and minor operations a local anesthetic.

"As these definitions no longer apply, we await an answer to the question."

D. C. HOWARD, M.D., Superintendent,
Garfield Memorial Hospital, Washington, D.C.:

"The present classification of operations as major and minor is most unsatisfactory. An arbitrary rule of thumb, which varies in different institutions, produces operative statistics that are inaccurate and without scientific value. My opinion is that every operation in which a general anesthetic is used should be classed as major. Further, it may be well to consider as major any operation in which incisions are made through tissues below the subcutaneous and submucous layers. This would reduce the minor class to a comparatively small group. The important thing is to secure a uniform definition in accordance with a well-defined standard.

"I should welcome the establishment of a standard for classification that would make statistics of operations properly comparable."

N. N. WOOD, M.D., Superintendent,
Los Angeles General Hospital, Los Angeles, Calif.:

"The term major operation is hardly used at all in this hospital, possibly because there are no operating room or anesthetic charges, since everything is included in the per diem charge.

"Therefore, the question of the distinction between a major and minor operation seems to me to be purely academic, and we use the term as little as possible. I do recall, however, having had occasion to tell some of the staff that it seemed to me to be unwise and unsafe to speak of every technically trivial or simple operative procedure as a minor operation, when, not infrequently, our attention has been called to the serious results of such a trivial operation as an adenoidectomy, an exploratory puncture or even a tonsillectomy, in cases of certain patients who were in a weakened condition or who might react unfavorably to the slightest operative procedure, the effect of which on the average normal patient would be considered entirely negligible."

C. G. PARNALL, M.D., Medical Director,
Rochester General Hospital, Rochester, N. Y.:

"A major operation, from a surgical standpoint, is one which involves considerable risk of life. A minor operation is one which, under ordinary conditions in a modern hospital, is not likely to incur serious risk. For a major operation more extensive preparation is usually necessary;

a general anesthetic is usually required although nowadays extensive operations of a major character are frequently done under local anesthesia.

"Any operation requiring a general anesthetic is, to a certain extent at least, a major operation because the anesthetic itself involves a certain degree of risk. An operation involving no great risk of life may, from the hospital's standpoint, assume the proportions of a major operation if it is extensive and if it requires a great deal of special preparation in the way of operating room service and supplies.

"A major operation potentially dangerous may in reality carry, on the average, no more risk than a minor surgical procedure. A clean appendectomy, for instance, is a comparatively simple and trivial operation. Its danger lies in the fact that the peritoneal cavity is opened and in that procedure there is always a possibility of infection.

"In a general way, any operation requiring the opening of the cranial, thoracic, peritoneal or pelvic cavities is a major operation. Operations on the spine, the joints, and the nervous system should be considered major; likewise extensive amputations or operations for injuries.

"Among common operations that might be qualified as minor are removal of tonsils, extractions of teeth, suturing of small wounds, amputation of digits, and incision of abscesses."

D. M. MORRILL, M.D., Director,
Blodgett Memorial Hospital, Grand Rapids, Mich.:

"I feel I would as nearly define a major operation in two words as in two thousand. First of all, I would say that depends on whether one is defining this term from the point of view of the adjustment of operating room charges, therefore considering the number of assistants, time involved, and surgical supplies used as primary in your consideration, or whether one is to consider the term from the point of view of surgical risk to the patient.

"Considering this latter phase, I would say that any surgical procedure no matter how brief or relatively simple, which involves particularly vital anatomical areas, or which is commonly attended by a reasonably high percentage of morbidity in the way of complications, is a major operation.

"On the other hand, for purposes of hospital economics, it is our practice to classify as major procedures principally those requiring general anaesthesia, one or more scrubbed nurse assistants and a fully set-up surgical room. Surgical procedures vary so extensively in degree, in consideration of resistance and general constitutional condition of the patient that I really feel that to try to outline completely, what is a major operation, is altogether beyond me and a rather dangerous question to attempt to set up a standard for its answer."

WALTER E. LIST, M.D., Superintendent,
Minneapolis General Hospital, Minneapolis:

"After a final analysis, the term major operations seems to me to be almost impossible to define.

"As one surgeon expressed it, any operation upon his father, mother, sister, brother, wife or children would be considered a major operation.

"Another surgeon stated that it would be easier to define a minor operation than a major operation, and he classified in the minor operative group small, limited, superficial lacerations, superficial abscesses and boils. Everything else he would consider in the major operative group.

"In my judgment, the terms are relative and depend upon individual opinion."



General view of hospital for physically sick, Alton State Hospital, Alton, Ill.

CARING FOR PSYCHOPATHIC PATIENTS WHO ARE PHYSICALLY SICK

By A. L. Bowen, Former Superintendent of Charities, Illinois State Department of Public Welfare, Springfield, Ill.

IN THE "lunatic asylum" days, the mentally ill, when physically sick, were treated on the wards and either recovered or died there, often without so much as a screen around the bed. While the mentally ill suffer from all the physical ills that flesh is heir to, in addition to their mental disorders, it took a long time to convince state legislatures that special wards or hospitals were needed in the "asylums."

The first improvement in this direction was a ward in the custodial department, set aside for the physically sick. To it transfers were made when necessary. These wards, in truth, were combined infirmaries and hospitals. They sheltered many of the class usually referred to as the chronically sick. Ambulatory and semi-ambulatory men and women, the senile, sufferers from old abscesses and cripples. At that time surgery for the mentally ill was generally discouraged. Not much was done in this specialty until a better form of hospital began to evolve and more attention was paid to the role of physical sickness in mental diseases.

The first hospital units designed for this particular purpose in detached buildings often included a reception service. The idea of a big building has long been fixed in the minds of those who plan state hospitals. It seems to be cheaper to build and to operate a huge structure. The mistake of such a combination was soon demonstrated. Then state hospital authorities settled upon a

plan similar to the general layout but big enough to accommodate what are in fact infirmary types. This form prevails in many states even now.

The latest and the ideal plan is a general hospital detached and just large enough to accommodate the dispensary, clinical, surgical and general medical needs of the mentally ill community to which it is to cater.

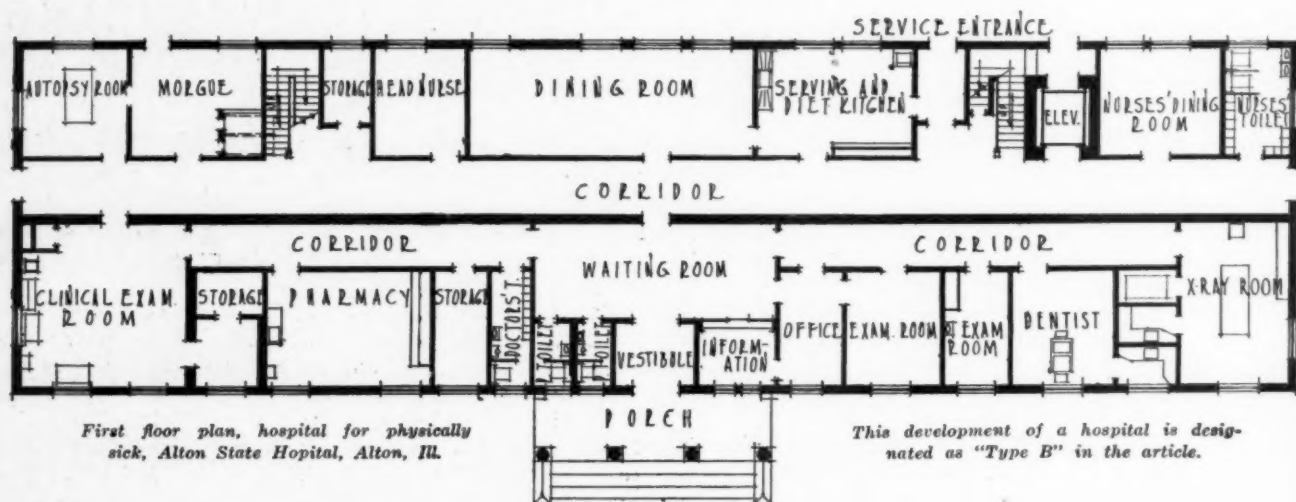
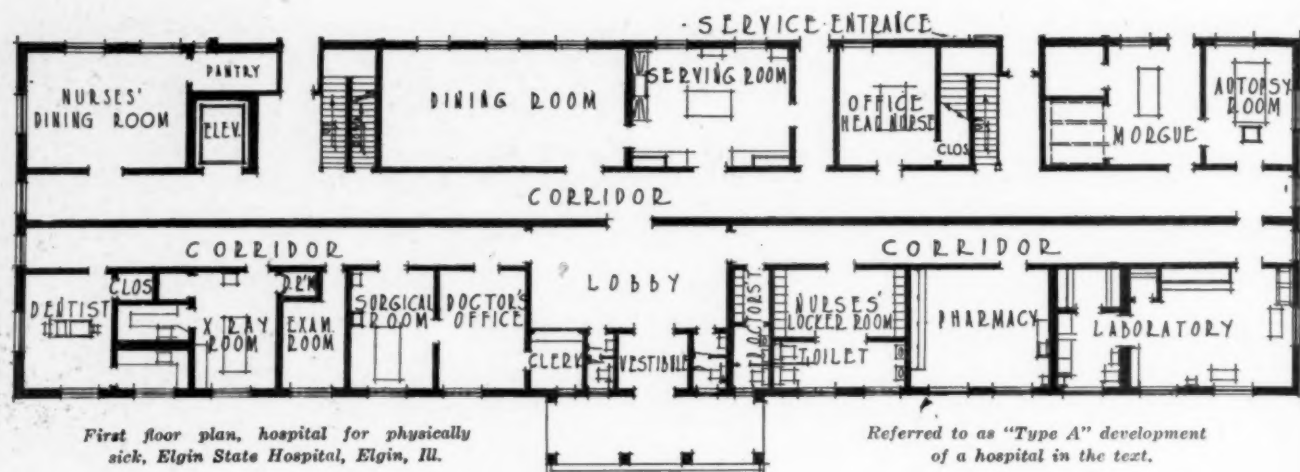
Illinois determined upon this type during the period from 1917 to 1921, adopted plans and started the work of construction. Three such buildings were designed. Two are now complete and occupied. They are the Elgin State Hospital, Elgin, and the Alton State Hospital, Alton. The other will be erected soon at the Dixon State Colony, Dixon.

All other Illinois state hospitals and colonies have detached hospital buildings but all of them partake more or less of the hospital and infirmary combination.

These three are regarded in Illinois as the last word in state hospital facilities for the physically sick. Much time was devoted to the details of their interior arrangement. Careful surveys were made to determine accurately how many actually need hospital care in a state hospital of 2500 mental patients, how many in one of 3,500 and how many in one of 5,000, inasmuch as both the Alton and Dixon institutions are to be expanded to this capacity. The ratio of admissions and the character of population from which they are drawn were also considered.



Entrance to hospital for physically sick, Elgin State Hospital, Elgin, Ill.



At the Elgin State Hospital with 2,600 or 2,800 patients from industrial and metropolitan districts, and an active receiving service, it was found that a hospital of eighty beds would accommodate the physically sick. A building of two stories was designed to house the administration, visitors' reception rooms, the various dispensary services, all the laboratories, x-ray rooms, the dentist, diet kitchens, the sick employees, a lecture room, class-rooms and a morgue. The wards for the bed patients are two one-story wings, erected at right angles to the two-story section. If more bed space is needed wings may be added.

These wings include small dormitories, single and double rooms and adequate toilet facilities and solariums.

"Type B" Development

The hospital at Alton was designed after the same principle, but topography, architectural effects, and future growth made it desirable that the one-story wards be on the axis of the main building. Enlargements are possible with this plan more easily than with the first one described. In the plans accompanying this article the Elgin building is called "Type A" and the Alton, "Type B." Both buildings are attractive to the eye and convey the idea of the general hospital. Their interiors are light, well ventilated, convenient in every respect and undoubtedly will stimulate interest among the medical staff in the physically sick insane, and do much to encourage the practice of general medicine as well as the specialties, particularly those for the care of mental patients.

The interior arrangements were made by Dr. H. Doug-

las Singer, at that time alienist of the department of public welfare and have been completed and developed by his successor, Dr. Charles F. Read. The architect was Edgar Martin, state consulting architect and at that time one of the members of the firm of Richard E. Schmidt, Garden and Martin, Chicago.

PLACING MENTAL AND PHYSICAL ILLNESS ON THE SAME BASIS

In discussing the importance of the psychopathic hospital movement of the present time, Dr. E. G. Ebaugh, director, Colorado Psychopathic Hospital, Denver, said in a recent issue of *Hospital Social Service*.

"We feel that the psychopathic hospital movement will prove a success wherever it is inaugurated. It is the natural outcome of many years of striving and earnest effort to place mental disorders on the same basis as physical disorders. We are approaching the time when general hospitals with their splendid delivery rooms, solariums for tuberculosis, excellent orthopedic appliances and apparatus and modern facilities of all types will also have provisions for the adequate care and treatment of mental patients."

Primarily, social service in the hospital is to supplement medical with social science, for the purpose of more accurate diagnosis and more effectual medical treatment, and involves the giving of direct relief only, when no other adjustment is possible and it is necessary for the carrying out of the physician's or worker's plan of treatment.—Hilda Colgate Baker, in *Hospital Social Service*.

DOES OCCUPATIONAL WORK HASTEN RECOVERY OF THE CRIPPLED?

By Loring T. Swaim, M.D.,
Boston, Mass.

ORTHOPEDIC surgery is the prevention and cure of deformity. It deals with the functional activity of the body, and where less of motion is present the object of treatment is to restore normal movement. It is readily seen, therefore, that occupational therapy has an important place in orthopedic surgery, since all forms of physical work require definite actions of the body. Moreover, these movements can be graded and measured, and the degree of activity charted in curves. This quality of the work makes it interesting for the therapist, since results are definitely and graphically shown from day to day. The loss of motion may be due to nerve injury, muscle injury or joint injury, or a combination of all three.

These may be due to varied causes, such as infantile paralysis, spastic paralysis, gun shot nerve injuries and fractures involving the nerve. The disability from a nerve injury is the result of the muscle weakness. A paralysis of a group of muscles supplied by one nerve causes contractures in the strong opponents and produces deformity. Of course, in this group of injuries occupational therapy does not affect the nerve supply but it develops what is left of the muscle and attempts to keep the tone. Its chief object is to prevent contractures and deformity.

Where the nerve supply is intact but the muscles are weak, undeveloped or restricted, for various reasons, occupation prevents atrophy, improper development, and produces greater strength to overcome limited movements.

Charts of Movement Progress

Probably the greatest use for occupational therapy is to secure normal movements in joints when they are limited through disease, after fractures, splints, casts, operation and arthritis. Occupational therapy has its largest application in arthritis for the following reasons: the work can be made to produce every known movement of any joint in the body; it can be graded to any desired effort and it can be controlled. But best of all its effects can be charted and measured with considerable accuracy so that at any time the worker can judge the results on the patient. Work of this kind requires considerable ingenuity in adapting the apparatus used to the particular movement desired. It is so easy for the patient to use his good muscles or accomplish the movement with a good joint that the teacher must guard against this natural tendency. Not only must the work be chosen that requires one or two single movements at a time but it must be impossible to do without the desired movement. Therefore, the method of work is far more important than the work itself.

The patient's gratification is centered in the improved motion rather than in the joy of the work or its perfection. For example, a man has arthritis of his left hip which has stiffened it so that the range of motion is not enough to allow him to sit in a chair comfortably or fully to extend the leg in standing. To overcome this he is started on a bicycle jig saw that requires separate use of both hips. The length of the pedal cranks is short at first, he is strapped to his chair to control the pelvis, and his good hip is used to force his left into action as the pedals go over and over. At first this is done without sawing. No

work is done until the motion has increased enough to allow him to stretch forward to the saw. Then the pedal cranks are lengthened and unconsciously he stretches more and more and increases his motion. The same is true of knotting cord chains for motion of the shoulders, loom work for the elbows, back and shoulders. The repetition of the stretch loosens stiff joints and by muscle development causes a greater force to be exerted on the joint.

One of the chief beneficial results of motion of any kind is to increase blood supply. Increased blood flow helps repair in fractures, injured muscles and diseased joints, particularly arthritis, so that occupational therapy not only overcomes functional disability but increases the actual healing processes.

Of course there is the mental effect of work and the joy of accomplishment but in this type of case the work is of no lasting benefit unless its object is to restore motion. Therefore, the patient does not choose his occupation (of course in so far as possible wishes are taken into account) and the kind and method of work are chosen for orthopedic reasons.

From the foregoing it is clear that complete understanding and cooperation between the occupational therapist and the physician are essential for success. Each contributes respectively expert knowledge of crafts and the movements involved, and an understanding of anatomical injury and motions that will benefit it. The orthopedic occupational therapist must know anatomy of joint and muscles and their usual movements.

The positions of the patient at work, and the positions of work itself are exceedingly important details for the occupational therapist to consider since the success often depends on the repetition of one special act. If wrong, harm may result. Frequently separate occupations are necessary for one arthritic patient in order to correct several disabilities. These can be carried along at the same time, each being used for different motions, no one of which over-fatigues the patient.

Test of Resourcefulness

Patience and an inexhaustible resourcefulness are required for this work. New ways of doing old things are tests of one's inventiveness. On these success depends.

In no other branch of occupational work can damage be done so easily as in orthopedic, reconstructional therapy. Over-use, too hard work, improved adaptation actually do harm in joint and muscle cases, chiefly through fatigue. Fatigue of an infantile paralytic muscle may mean permanent injury. Over-use of an arthritic joint causes stiffness rather than motion. Too hard work may start inflammation in a diseased joint or cause callus in a fractured joint. Therefore accurate observation is necessary, and to rule out the variable human element in this work graphic charts can be drawn measuring the degrees of motion. As in no other type of cases, these curves of the motions of each joint tell the story (good or bad) of the effects of the occupation. Whether the chosen work is effective or not, too hard, too easy, too long, too short, or improperly adapted to the patient is shown. Weekly charts of this nature are easily read and can be relied

upon. They add to the patient's interest and are like a temperature chart for the physician at his visits.

When dealing with muscle training it must always be remembered that the principle of growth is rest and exercise, and a judicious use of each produces the best results. The greatest single danger in orthopedic occupational therapy is fatigue, which does more permanent harm than any one other factor and should be avoided at all hazards. No muscle or joint should ever be overused, lest it may not recover.

In orthopedic cases the choice of the occupation and its adaptation are almost limitless. With the proper ingenuity and knowledge of anatomy, there is no work or game which is not adaptable. One of the best examples of this is seen in the process of woolen cloth making. Picking, carding, spinning the thread, weaving the cloth, and, finally, cutting and sewing and fitting the clothes. They all require special movements of different joints and muscles.

Orthopedic occupational therapy requires accurate, ingenious adaptation and application of a larger number of occupations to specialized problems of anatomical deformities and limitations. It has as its chief object restoration of normal, coordinated use of nerves, muscles and joints. The work must be adapted to all parts of the body and worked out in conjunction with the anatomical knowledge and the desires of the physician for the individual patient.

HOW THE SICK WERE HOUSED IN THE EIGHTEENTH CENTURY

Eighteenth century hospitals show little, if any, improvement over those of the previous hundred years. There were a few outstanding hospitals, but the general level was much the same. Conditions in the Charity Hospital, Paris, appeared to be more sanitary than those in the seventeenth century Hotel Dieu.

An engraving of the infirmary of the Charity Hospital, made toward the end of the seventeenth century by Abraham Bosse, shows the brothers of St. Jean, who had charge of the hospital, serving food to the invalids. The engraving suggests the serving of broth or soup, bread and one or two other dishes. The Brothers were assisted in the serving, as well as the nursing, by Sisters. At this time the hospital was open to both men and women patients.

In the wards were a large number of beds all of which appear to be single. Each is in a cubicle enclosed by curtains with ornate valances that afforded an attractive haven for vermin.

An investigation of the Paris hospitals was made in the latter part of the century by that well-known philanthropist, Piarron de Chamousset, who donated his large fortune to the betterment of hospitals and converted his luxurious mansion into a hospital. According to him the inmates of the Charity Hospital were provided with separate beds and had plenty of light and air. The death rate averaged about one-eighth of the patients admitted. This was about the same percentage found in the Versailles Hospital, but the rate was, of course, much higher in the Hotel Dieu.

Conditions in the Hotel Dieu were described by Chamousset as follows:

Let the people picture to themselves a room in which patients suffering from every kind of disease are massed together, and from want of space are often obliged to sleep three, four, five, or six in a bed; the dying and convalescent lying next to one another; the dead beside the living; the air tainted with the emanations from many

diseased bodies, and carrying with it the germ of many fresh diseases. The air breathed in the room would be vitiated even if inhabited by as many in perfect health.

Chamousset tells us that between 1737 and 1748, 251,178 patients had been admitted to the Hotel Dieu, and of this number 61,091 had died in the hospital. From these figures he concluded that they would have been better off if they had stayed in their hovels, with no other assistance than what they might have obtained from their neighbors.

Before Chamousset died in 1774, he had founded an institution for the care of babies, and attempted to substitute fresh milk and barley water in place of wet nurses, and to introduce the use of filtered water.

Largely because of his influence, Louis XVI in 1781 established 2,500 separate beds in the Hotel Dieu and 250 double beds with a partition through the center.

Nevertheless, in the Hotel Dieu, in 1788, there were 1,220 beds for two or more patients up to the number of six, and only 486 beds that were occupied by one patient.

The ventilation was so bad that the attendants held sponges to their noses while working in some of the wards.

Septic fevers were the rule, recoveries from surgical operations were rare, and there was a general mortality of about 20 per cent.

A few years later during the Revolution partitions were made in the beds, so that the patients with contagious diseases could be separated from the others.

An interesting account of an eighteenth century hospital for the insane, Saint Luke's Hospital, London, is preserved in a work of that period. It was first established in war fields in 1751, and in 1872 was rebuilt at a cost of 40,000 pounds. It was of brick and stone, almost 500 feet long and had three stories.

One end was occupied by women, the other by men. In each end was a spacious sitting room used by convalescents for a dining and living room. The hall for women is illustrated in a plate accompanying the account. Like modern state hospitals, the hospital had two gardens, one for each sex. From 1751 to 1800, according to statistics, there were 4,000 patients discharged from the hospital as cured.

One of the best of the charity hospitals in England was the institution at Middlesex, founded in 1745 for the indigent sick and lame. Two years later a maternity ward was added for poor patients.

In 1755 the institution was moved and large new buildings were erected. The maternity wards were isolated at one end of the building, and everything about the hospital was supposed to be of the most up-to-date character.

A department for cancerous cases was added about 1785 as the result of an endowment of about 300 pounds a year. A picture of the interior of the hospital at about that time shows a ward for women with single beds, an uncovered floor, and the characteristic fireplace of the time.

A subscription of three guineas a year entitled the donor to be a governor of the hospital, together with the privilege of having one patient and one maternity case in the hospital at the same time.

Three well-known physicians visited the hospital three days a week without pay, and three surgeons attended there on the same basis. Accidents were admitted without recommendation or formalities, and there was a free clinic for outsiders once a week.

According to a list of that date, there were eighteen hospitals located near London at the end of the eighteenth century.

WHAT PHYSIOTHERAPY MAY DO TO AID ORTHOPEDIC SURGERY*

By F. H. Ewerhardt, M.D.

St. Louis, Mo.

THE subject matter contained in this paper, "What Physiotherapy May Do to Aid Orthopedic Surgery," is based on experience obtained in the physiotherapy department of the Washington University School of Medicine, St. Louis. It operates in intimate correlation with the orthopedic department which sends us patients with a definite diagnosis and request for treatment. This is also true of private patients who are sent to us by surgeons not connected with our hospital. This department was opened ten years ago and thus far some seventy thousand (70,000) treatments have been given. I wish to make it clear that when I speak of physiotherapy I do not mean electrotherapy exclusively, which seems to be the vogue in many places. In our department we employ, in addition to the electric current, water, light, massage, and exercise, and we are firmly convinced that many times we obtain results with one when another seems an utter failure.

The types of cases that most frequently come to us from the orthopedic surgeons are as follows: fractures, dislocations, and sprains; muscle tendon and peripheral nerve injuries; arthritis of all degrees; the so-called painful shoulder, including subdeltoid, and subacromial bursitis, periartthritis; injured deltoid, supraspinatus and biceps muscles; calcium deposits, etc., flaccid and spastic paralysis, flat and club feet; curvature deformities of the spine including scoliosis, kyphosis, lordosis, and the very common functional faulty posture.

General Outline of Treatment Groups

It is obviously impossible to go into detail regarding the treatment of each of these named conditions for which reason we will aim to discuss them in groups and present a general outline of rational physiotherapeutic treatments supplementary to that given by the orthopedic surgeon himself.

Our equipment consists of several high-frequency machines, vibrators, the Morse wave generator, mercury vapor and carbon lamps, high powered incandescent lamps and infra-red apparatus. In the hydriatic section we employ the commonly known needle-fan-shower Scotch douche unit and the electric light cabinet, an effervescent bath outfit and the whirlpool bath. We have a medical gymnasium which includes in its equipment besides the usual apparatus, a number of special mechanical devices for use in the treatment of muscle, nerve and joint defects. With this variety of modalities at our command we are able to change our treatments as conditions may require. It would be exceedingly difficult to say which particular section is of the most value to us, for we find that in many cases one is a complement to the other.

In the treatment of fractures we feel that each individual case is an entity in itself and should be treated as such, but in general we have definite symptoms which we aim to meet by means of one or another modality. This may perhaps be best illustrated by using the treatment of Colles' fracture as an example. We prefer to have this fracture immediately and very frequently it is

brought to us within twenty-four hours. Our first aim is to remove pain, swelling and spasm, and we employ for this purpose heat and massage. Heat may be given in the form of diathermy or the deep radiant light which in turn is followed by light stroking effleurage and deep drainage massage above the seat of fracture. This is followed by maximum passive flexion, extension, and circumduction of the fingers, which, of necessity, must be passive, for usually the patient will not himself flex or extend the fingers to their maximum degree. As soon as union is firmly established we place the patient on selective exercise.

Teach Simple Movements First

We choose for this purpose an ordinary one pound Indian club and teach the patient simple movements which graduate progressively into more intricate ones. We find that by means of this procedure we can get the patient to exercise actively the intrinsic muscles of the fingers as well as the larger groups of the forearm. This procedure excites interest on the part of the patient to learn the particular movements involved and he becomes less conscious of his injuries, and therefore more cooperative. We are quite convinced that by this method we have succeeded in definitely decreasing the period of convalescence. It must, of course, be assumed that the Indian club exercises just mentioned are only given after a sufficient period has elapsed to cause union and avoid displacement, which may be anywhere from ten to twenty days in case of a Colles' fracture. In cases where we are reluctant to employ active exercise as described, we use the sinusoidal current. This scheme of treatment is a general outline which we follow in all kinds of fractures, modifying the treatment according to the type of fracture, and the degree of displacement.

Arthritis in its various phases is treated in our department by every method in our possession. As we all well know arthritis is one of the most intractable conditions with which we come in contact. In general we apply heat by means of diathermy, radiant light and the whirlpool baths, followed by massage, active and passive movements, galvanism and ionization. To strengthen the atrophied muscles which are almost always present, we also employ the sinusoidal current. To stimulate resistive power we give to our patients our pet tonic treatment of five to ten minutes in the electric lighted cabinet, followed by the needle bath and Scotch douche. In some cases this is followed by ultraviolet radiation.

An interesting condition which frequently is referred to us is the so-called painful shoulder. We include in this definition the various injuries and inflammations to which this joint is susceptible. The treatment to some extent is identical. The aim is the relief of pain and the restoration of function, for so long as these symptoms are present the removal of spasm is impossible. For the first we employ diathermy, radiant heat and positive galvanism. If adhesions are present the arm is either manipulated manually or we may use the surging sinusoidal wave and massage. This may or may not terminate the treatment for the day. If possible we next direct our attention to

*Read before the fourth annual physiotherapeutic convention held in Chicago, October 12-16, 1925.

the spasm, atrophy and faulty coordination for the correction of which we resort to exercises. We use exercises of various types, active, passive and resistive. The patient is generally reluctant voluntarily to abduct his arm and if an effort be made to raise it passively he brings about a defensive muscular contraction, either consciously or unconsciously which prohibits or, at least markedly interferes with, the attempted movement. This true passive movement can be successfully carried out only when extreme caution is used by the operator and when he is working in absolute harmony with the patient. The neuromuscular system is an intricate piece of apparatus and responds quite definitely in accordance with recognized physiological laws.

Flat Feet Common Condition

Flat feet is a very common condition both in the growing child and in the adult. If not of a traumatic or arthritic nature we may well assume that the etiology in the main is a weakening of the muscular group which normally supports the arch. It is obvious, therefore, that the treatment shall be directed to strengthening this weakness. We employ for this purpose methods that will stimulate the vaso-motor system, and to my mind the contrast or the whirlpool bath stands out pre-eminently over and above all other methods. The second point is to strengthen these weakened muscles by the use of the sinusoidal current, or what I much prefer, active exercise on the part of the patient. These should be movements in the direction of adduction, inversion with flexion of the toes avoiding, as much as possible, abduction.

The so-called sacro-iliac and other allied painful symptoms of the lower back are frequently sent to us by the orthopedic surgeon. These cases are free of any organic pelvic condition and are purely orthopedic cases. The pain may be the result of a number of causes and each must be handled in accordance with the findings. After removing the cause and applying proper corsets, shoes, and perhaps belts, the patient still has pain and discomforts and the surgeon comes to the physiotherapist for assistance. The patient pleads to be relieved of his pain and of the frequently recurring condition. We treat the symptoms as noted with the various heat giving modalities and in certain selective cases we add certain movements. It is our theory that in these cases the intense spasticity of the lower back muscles are a factor in the frequently recurring symptoms and to a large extent responsible for the uncomfortable state of mind with which these patients are obsessed. They constantly fear that the slightest movement will bring about a recurrence of their painful condition which fact produces subconsciously a spastic muscular contraction of the lower back muscles. It is a defensive act to immobilize the lower spine. This in turn brings about an error in the proper coordination of these muscles with the result that any inconsequent movement as, for instance, stooping forward to tie the shoe string, may bring about a recurrence of the painful condition. To remedy this we employ a type of rhythmic movement which we have found extremely beneficial. These are not developmental exercises, but movements intended to restore coordination.

You will have noticed from the foregoing that I am an advocate of physical exercise as a mode of physiotherapy. If judiciously and scientifically applied, it can be made to play an important role in the treatment of many medical and surgical cases. As you well know, however, few doctors are qualified to prescribe it, which is equally true of electrotherapy. Improperly prescribed and applied exercises may be injurious not only to the patient but they

reflect badly on the medical profession as well. I have known of many patients with faulty posture and curvatures of the spine who have suffered because of these facts. In several cases abdominal exercises were prescribed for the correction of lordosis which was caused by a weakening of the lower spinal muscles and not, as the doctor thought, by the abdominal group. He wondered why the condition did not improve. We all know of cases of poliomyelitis which have been immeasurably and irreparably damaged by indiscreet and ill-advised exercises. Those types of cases come distinctly within the scope of physiotherapy. It is not our function, however, at this time to go into details concerning this phase of treatment in curvatures and paralysis. Each in itself forms a topic for a complete paper. Briefly, however, we may state that in flaccid paralysis we employ heat in its various forms for the purpose of improving the general nutrition of the muscles and as a preparation for massage and exercise which follows. We also use the galvanic, the faradic and the sinusoidal currents for the purpose of improving nerve and muscle tissue. All these procedures, however, do nothing toward re-establishing voluntary motion. This can only be brought about by one agency and only one, namely, voluntary purposeful active exercise. Exceedingly great care must be used to determine the degree of properly selected exercises.

I have emphasized somewhat the use of exercise as a remedial agent because I believe it to be of great value and should receive more space on our programs. This should not be construed to mean that I undervalue the other modalities. I do not. I believe the introduction of diathermy to be a most important landmark in the field of therapeutics. The same may be said of the ultraviolet ray. Physiotherapy has proved its value and has imbedded itself in the consciousness of the medical profession. There are, however, several forces opposing its more general acceptance. One is the almost unbounded claims made by some of its adherents. Another is the practice of the various physical modalities by nonmedical persons who are also otherwise not properly qualified.

PER CAPITA REDUCED IN GOVERNMENT HOSPITALS

The annual report of the Surgeon General, U. S. Army, to the Secretary of War for the year 1925 divulges the information that the average number of patients in Army and associated hospitals each day during the year 1925 was 6,262, of which 30 per cent were beneficiaries of the U. S. Veterans' Bureau.

The total cost of this hospitalization, including repairs to buildings and such slight additional construction as was done, and the maintenance of roads, walks and drives was \$4.95 per patient per day or thirty-three cents below the cost during the preceding year.

A century or more before Pepin le Boef, who in 757 A. D. forbade by rescript the marriage of a leper with a healthy woman, hospitals exclusively for lepers, under monastic management, were erected at important centers. London, as early as 1118, established a leprosarium for absolute sequestration. During the reign of Louis VIII the disease had made such astonishing progress that upon his death, in 1225, he left a large sum of money with the command that it be divided among the 2,000 lazarettos for leprosy in his dominions. This large number of leper hospitals remained undiminished until nearly the sixteenth century.—Burdett.

YOUR EVERYDAY PROBLEM

A department devoted to the informal discussion of problems arising in the everyday life of the hospital superintendent.

1. Should the hospital charge members of its visiting staff for meals at the institution?

This question is one for which there appears to be no accepted solution. Some private institutions argue that since the visiting physician derives a major portion of his income from the treatment of patients in the private rooms and wards of the hospital, the physician should pay for his meals. It is also often felt that the treatment of ward patients for which the physician is not permitted to charge in a way is balanced by the private room facilities offered for the treatment of his private patients.

The financial status of the hospital is another factor that more or less affects this policy. On the other hand, many hospitals believe that the comradery that exists when visiting chiefs and interns gather about a table at lunch, and informally discuss their diagnostic and administrative problems recompenses the hospital for the price of food consumed. There is no doubt that the heightened morale incident to an appreciation on the part of the visiting staff of such generosity on the hospital's part will react favorably in providing better care for the patients.

It is usually possible to enact rules covering those eligible for meals in the hospital, only those chiefs on duty being permitted the privileges of the dining room. Moreover, it would seem that the hospital would secure the advantage of receiving more of the visiting physician's time, were he to know that if the meal hour arrived during his visit at the hospital, he would not have to curtail his round making to secure his lunch before meeting his afternoon engagements.

Looking at this matter from every angle, it would appear that while local conditions will no doubt affect the solution of this problem, the hospital in the long run, will gain by permitting physicians to lunch at the hospital, should attendance on patients cause them to be there at mealtime.

2. Who should meet the most of antirabic and other expensive treatment often required by the indigent patient?

A basic statement that cannot be refuted in hospital practice, is that the hospital has a moral obligation to furnish any and all types of treatment that favor the patient's recovery, and serve to prevent any untoward accidents that will endanger his life or health.

In many localities, the money secured from the dog tax is utilized by the county commissioners to defray the expense of treatment of those bitten by animals infected by rabies.

Sometimes the process of securing payment for this treatment is so complicated and bound up with legal red tape that the hospital prefers to stand the expense of such sera without endeavoring to secure payment therefor from

other quarters. In the case of the use of antitetanic and antistreptococcic serum or other biological products, which are often of no little expense, the duty of the hospital is clear: treat the patient first, and later endeavor to collect a recompense for the drugs used. Even though the patient is known to be without funds and friends, no hospital ever views the question of saving human life in the light of the expense that it entails.

3. What represents the ideal consent for operation, and how should it be filed?

It appears that hospitals the country over are coming to realize the importance of securing a signed consent for operation before any surgical step is taken. There are not a few cases on record in which the life of a surgeon has been made miserable, and in which his professional and personal reputation has been placed in jeopardy because there existed no such contract permitting him to perform the surgical operation in question. Particularly is this true when the operation concerned is one for the excision of pelvic organs in the female.

The operation consent must be carefully worded and, above all, inclusive of any condition that may be discovered when the abdomen has been opened, and that was not suspected prior to the beginning of the surgical procedure. The consent, of course, must be given by the nearest responsible relative, that is, in the wife, the husband—and vice versa—in the child, the father or mother—in the father or mother, the son or daughter.

It is often considered sufficient, however, if the patient is over twenty-one years of age, for him or her alone to sign the permission. In the case of an operation on the pelvic organs of the female in a married woman, it is usually safer to have a joint signature of both the husband and the wife.

The operation consent is usually worded to include permission "for any surgical procedure that may arise in the course of the operation, subject to the judgment of the surgeon in charge."

The importance of securing the permit cannot be too strongly emphasized.

The filing of the operation permit is a matter concerning which there is some difference of opinion. Some hospitals use books of size in which these permits are bound, and which serve to preserve the signed permit. Others use a detached form that is pasted on the patient's chart and bound therewith. Others have a printed form that is attached as an integral part to the anesthetic chart, and which, after having been properly executed, is thereafter bound with the chart. It appears best for the operation permission not to be separated from the patient's chart. Thus it will not only be available for future reference, but will be less likely to be mislaid than if it is permanently separated from the individual's record. The permit should be as easy of access as the chart.

4. Should a breakage fee be charged interns on the laboratory service?

That some interns have a poorly developed sense of property responsibility, is certain. The breakage of blood counting pipettes and slides, beakers, hemoglobinometers, and similar expensive laboratory apparatus by interns and other laboratory workers, is, in a figurative sense, appalling. The assignment of a locker to each new intern, in which is deposited a complete set of instruments and apparatus necessary for performing the work expected of him and the exaction of a small laboratory fee, usually in no way commensurate with the cost of the materials to be used, has been found, in many hospitals, to be conducive to greater care in the handling of this apparatus by the physician.

Interns, however, are notoriously impecunious, and sometimes it would appear not only unjust but impossible to exact a fee of any size from them. It is usually best to require a definite receipt from the intern for all apparatus turned over to him, and to explain that he will be expected to replace glassware and breakable instruments if it can be proved that he has been careless in their use. If carelessness is found to exist, the temporary execution of a breakage fee will usually, more or less permanently, solve the problem.

5. Are monthly inventories of instruments and equipment a waste of the head nurse's time? Should they not be taken at longer intervals?

There is no greater difficulty than the hospital superintendent encounters than to prevent the loss, through carelessness or theft, of the hospital's property. Fortunately, the number of unscrupulous nurses and doctors is comparatively negligible. There is no greater stimulus to care of such hospital property as instruments, ward, laboratory supplies and rubber goods, than the fact that there should be a monthly inventory of these articles. It will be argued, on the other hand, that the hospital nurse of today is encumbered with a great deal of clerical work, and that the time so consumed, should be given to the supervision of the care of patients. It is contended that the nurse should nurse, and not spend her valuable time keeping books.

But the head nurse of any hospital department is not only the supervisor of the actual scientific nursing care of patients but she is also, in a large measure, the overseer of the physical property of her department. Since she is responsible to her superintendent of nurses for the protection of property in her division, she cannot refuse to take any step necessary properly to safeguard the hospital's supplies or equipment.

The monthly inventory of instruments, rubber goods, laboratory supplies, blood pressure machines and other equipment is much worth while from the economic standpoint, and while time consuming, it appears to be a sound policy to insist that such a routine accounting be carried out.

6. Does a hospital have a moral obligation to its community to maintain an ambulance service?

The modern conception of the hospital's duty to its community is one of ever-widening scope. It has been repeatedly stated that the hospital cannot, figuratively, sit within its walls, and accept for treatment only those patients who are brought to it. That is not the procedure of the modern hospital which is concerned with disease prevention and health activities.

This statement implies that the responsibility of the

hospital, in a measure at least, begins the minute the patient becomes ill at home. It means that the blame for any delay in initiating institutional treatment, should such care be needed, can be laid at the door of the hospital.

To secure prompt ambulance service from private agencies, is oftentimes impossible. Frequently it is just as impossible, from the standpoint of the patient, to meet the necessary expense incident to hiring a private ambulance. The hospital, not maintaining its ambulance for profit, is able to furnish this service at a minimum of expense to its community. It appears, therefore, not unfair to state that the hospital does owe to its community the maintenance of a transportation service that will facilitate the prompt removal from their homes, of those who are ill, and immediate treatment in the hospital ward.

7. What is the relation of the superintendent of nurses to graduate nurses on the private floor?

This is a problem of many local angles. If it is conceded that the superintendent of nurses is in charge of all nursing within the hospital, then it must be assumed that there is no class of nurses outside her jurisdiction. There is little difference of opinion in regard to the relationship of the superintendent of nurses to the pupils in the school of nursing, or to departmental graduate nurses.

At times, however, visiting physicians, particularly those representing the specialties, have a particular technique they desire to be carried out by the graduate nurses caring for their patients. However, this fact need not interfere with the principle involved.

In so far as the department, the observation of hospital rules, and the ethics of nursing are concerned, there is but one person in the hospital who should be qualified and empowered to insist that these details be observed by private duty nurses—the superintendent of nurses. Whenever there are set up, within the hospital, subdivisions that do not answer administratively through routine channels, then misunderstandings, lowered morale and lack of discipline, which react unfavorably on the hospital's reputation and on the care of the individual patient, most surely enter.

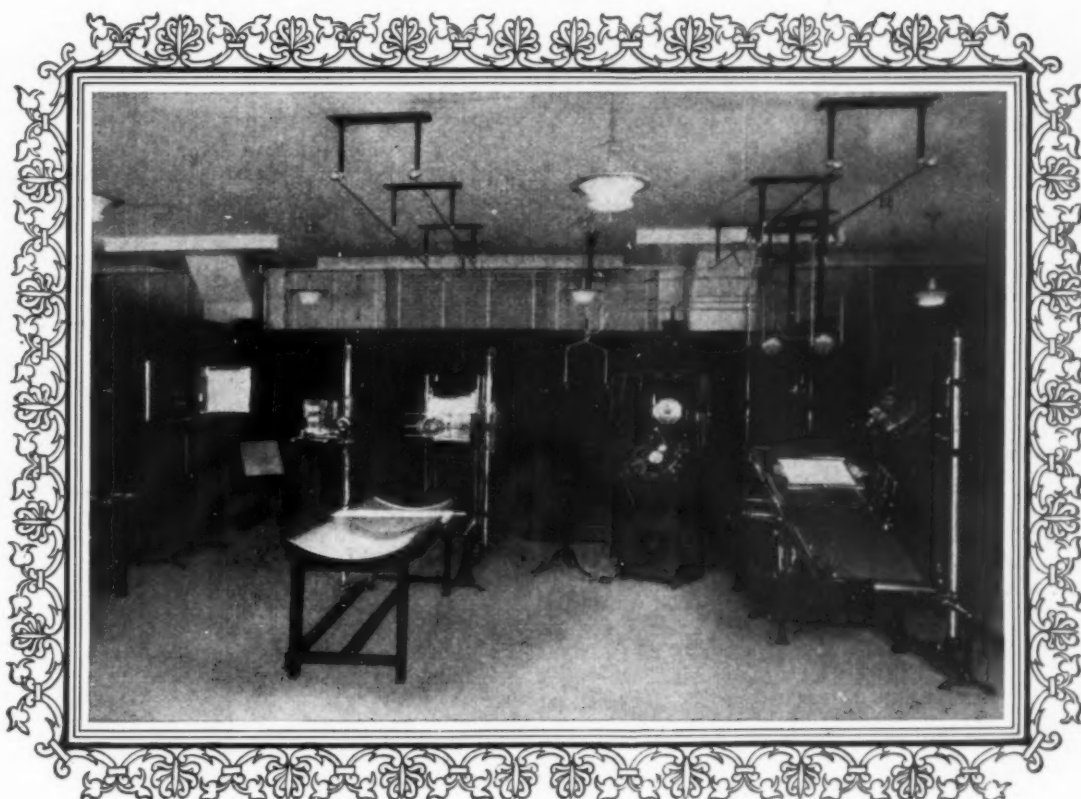
8. Is infectious linen safely sterilized by the routine washing and drying of the hospital laundry?

It is claimed by most companies manufacturing laundry machinery, that the ordinary washer, during its routine use, attains a heat that will safely sterilize linens. This statement is frequently supported by laboratory tests proving the sterility of linen thus washed.

Assuming that the statement of these companies is true, there enters the question of careless supervision while the machine is running, a shortened period of washing, the insufficient use of chlorin and other bleaching agents, which in themselves, are somewhat antiseptic in nature. Any such variation in washing technique would nullify the sterilizing effect of steam and chemicals.

In hospital practice, ward treatment of typhoid linen insures its sterility before it reaches the laundry. In many hospitals, particularly those where reclamation of gauze is practiced, a sterilizing washer within which fifteen pounds of steam pressure can be generated, is employed for this purpose.

It would appear best, where facilities are at hand, to sterilize in mattress sterilizers or in pressure washers, the linen of patients suffering with diseases that have been proved more or less easily transmissible. After this has been done, the linen can be safely mixed with articles from



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other departments without fear of transmitting contagion. It is far better to be over careful in this matter, than to run the risk of thus disseminating infections or contagions.

9. How can blankets be best cleansed?

For a full discussion of this subject, the reader is referred to the fifth edition of *THE MODERN HOSPITAL Year Book*, pages 267-268. Only a few of the most important points need be stressed here.

To free it from any removable dirt the blanket should be shaken and brushed before being placed in the washer.

To prevent hardening and shrinkage, the water employed in the various washing processes should be of approximately the same temperature, about 110° F. The use of too hot or too cold water in washing blankets shrinks them and makes the cleansing process more difficult. Too severe pounding of the blanket on the wheel, which tends to shrink it, is another evil to be avoided.

The soap used should contain no excess of alkali. If the water requires softening, borax or ammonia should be used for this purpose. Blankets should not be dried in a hot tumbler. If this machine is used, they should be removed before they are entirely dry. If room is available, drying on racks at the normal room temperature is a good plan.

Some hospitals that use a high percentage of wool in their blankets prefer to send these articles to an outside firm to be dry cleaned. Even though this practice is expensive, if high grade blankets are likely to be damaged in a laundry not properly equipped to handle this work, such a step would be economically justifiable.

10. How can mice and other vermin be eradicated from the kitchen and the storehouse?

Mice, rats, roaches and flies comprise the group of pests that not only disturb the dietitian's peace of mind, but cost the hospital a large sum every year. Even in buildings of modern construction these vermin are often found. The first step at eradication of rats and mice should be to provide suitable containers for cereals, vegetables, bread and other foodstuffs, so that these pests are unable to secure the food that attracts them. Rat proofing of floors and cupboards can be done by the use of zinc, galvanized iron or tin. The stopping of holes and runways with cement in which has been mixed ground glass, has also proved an efficient method of preventing these pests from entering the kitchen and the storehouse.

Almost every hospital has among its employees a man with a Daniel Boone instinct. To supply this individual with suitable traps and frequent encouragement results usually in ridding the hospital of a surprisingly large number of these wily rodents.

Poison is also an effective weapon to employ. In most cities there are commercial exterminators who guarantee to rid institutions of rats and mice for a specified sum. These companies usually possess some secret formula reputed to supersede others in effectiveness. The basis of these compounds is often arsenic, which is not only a deadly weapon, but is reputed to dry or desiccate its victim so as to prevent the creation of unsanitary and odorous after-complications.

The U. S. Department of Agriculture recommends the use of barium sulphate mixed with ground meat, cheese or some other food of which these animals are fond. If the hospital is to conduct its own rat and mouse campaign, frequent change of the type of poisoned bait used will add to its effectiveness.

Last, but not always least useful in eradicating rats

and mice, is the faithful, if not always aggressive, storehouse cat.

Cleanliness is surely more effective than godliness, in creating a flyless and roachless kitchen. Of great importance are tight and well-built screens in a successful fly campaign. But of the greatest effectiveness, although perhaps the most difficult to do, is the eradication of breeding places. Fly traps, which can be cheaply purchased, should be placed on wooden shelves outside the kitchen near each door. These will attract the insects from the screen and capture them before they have an opportunity to enter.

Black flag (malefern) powder propelled from a bellows around a room, the doors and windows being then tightly closed for a few hours, will kill all the flies there.

A cheap but effective spray, which has an oily base, carbolic acid and oil of mirbane as its chief ingredients, is also an efficient weapon.

Roaches gather where there is dampness, particularly about sinks and rotting wood. The liquid spray, suggested above, with an improvement in sanitation, is usually sufficient to rid the kitchen of these pests.

WHEN VISITORS ARE A MENACE

"Why do the superintendents of tuberculosis sanatoriums or any other form of sanatorium permit the annoyance of hordes of visitors?" asks a writer in the *Journal-Lancet*.

He comments upon the conditions in sanatoriums with which he is familiar where corridors are filled with visitors on Sunday afternoons. In one sanatorium where there were between 200 or 300 he asked the superintendent his attitude on the matter and was told that it had become a custom, now impossible to relieve. The superintendent said that the people demanded to see their friends in the hospital and that it was easier to let the crowd in than to attempt to explain why it was necessary to make them stay out. The refusal of the visitor seems to the lay people a very harsh measure. They know that their sick friends want to see them, and perhaps they do. They think that they can cheer up the sick better than anyone else, while as a matter of fact they simply leave a mark of injury by their discouraging attitude and unfavorable comments.

"Yet the thing goes on without any effort on the part of the hospital authorities to educate the people to the fact that visitors are unnecessary in the sickroom, and particularly in hospitals where contact diseases prevail. On the other hand there are the nervous and mental patients, some of them depressed, anxious, and worried because they do not know how to get at peace with themselves that is, they do not know how to rest. The same condition is found there, at times unless the authorities say frankly, 'No visitors.'

"This is done in other institutions. But can you imagine one who is worried, trying to get his mind in order, and trying to rest, being disturbed by a fatuous, feeble-minded visitor who often knows absolutely nothing about the necessity of leaving the patient alone where he can be quiet and at peace?"

In Spain leper houses are mentioned as early as 1067. In France, too, leprosy was common very early. In 1225, France, at that time comprised of about half of its present area, had about 2,000 leper hospitals, as is evident from the last will of Louis VIII, who donated 8,000 solidi to each of these institutions. In England, it seems, leprosariums were established much later.

If this isn't important to hospitals —what would be?

Here is what an official bulletin of the U. S. Government says about the value of plain unflavored Gelatine in combination with fruit juices:

"Desserts, which include succulent fruits and fruit juices, are particularly acceptable after a comparatively heavy meal. Gelatine is a good means of introducing fruit juices and to some extent also vegetable juices like those of tomatoes and cucumbers, into the diet. These juices contain vitamins, some of which are probably destroyed by heat, so that it is well to know a variety of ways of serving them raw. One of these ways is in the form of gelatine desserts."

Here is what a successful restaurant manager says about the economy of Gelatine in utilizing surplus fruits and their juices.

"This is where an unflavored gelatine counts in the restaurant business: One always has so many fruit juices to use up, but if you take a small amount of Knox, with these juices you can make wonderful desserts and salads, at little cost, where otherwise you'd have to throw away the juices. In fact, were it not for Knox Gelatine, we couldn't use the juices up as fast as we'd accumulate them. In the berry season there are always berries which have to be stewed up, or else thrown out, and it is cheaper to use gelatine and get some money out of the juices."

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Each 5-pound package of Knox Sparkling Gelatine makes 120 quarts of jelly, or 1440 generous servings. A comparison of these advantages with any other brand proves that Knox Gelatine is not only best but most economical in every way for hospital use.

A trial 5-pound package at \$1.50 a pound will be sent to any hospital direct upon request.

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TEACHING HEALTH IN THE SCHOOL OF NURSING

By Lina L. Davis, R.N., Director of Nursing, Santa Barbara Cottage Hospital,
Santa Barbara, Calif.

IN the last few years there has been sweeping over the country a great wave of health education. The public schools, churches, newspapers, magazines and even the "movies" have taken an active part in spreading the gospel of health and in giving instruction for securing and maintaining it.

The nursing profession has had a tremendous strain put upon it to furnish nurses for the public health field, which offers our greatest opportunity for "selling" the idea of health to the community. Hospitals which for centuries have considered that their aim is to care for and cure the sick are now broadening their activities to teach patients to be well and to live so that physically they can be most efficient.

Since the nurse is the point of contact with the patient, it is most important that the school of nursing recognize its responsibility in helping her to become an active saleswoman of the health idea, both while she is a student and later, when her opportunities are extended to the graduate field.

Living Examples of Health

If our nurses are to be advocates of health, they must be living examples of the subject they teach and it is for us to see that they are. Following is a brief sketch of our method of securing results at the Santa Barbara Cottage Hospital.

To insure that our students are of good physique and physically equal to the demands made upon them, we require that each present a doctor's certificate stating that she is in good health. This must be accompanied by a dentist's statement that her teeth are in good condition. Also, she must have been recently successfully vaccinated against smallpox. It is true that we do not require the rugged type of woman who was demanded twenty years ago, for we know that given the proper care and consideration during her training the girl of average strength and good health is quite equal to the duties she has to perform. She may even be admitted with a physical handicap which, under intelligent supervision, can be corrected. It is a well known fact that the regular routine of life in a school of nursing more often than not improves the health of the student. Soon after her admission she is given a careful examination by the medical director, who is a salaried officer of the staff. He has supervision of the health of the students and charge of them during illness. He gives advice as to any corrective measures

in regard to diet and exercise. The feet are examined by a specialist who prescribes the proper footwear. Later examinations are made yearly as a matter of routine and at other times whenever necessary. The weight is carefully watched and a chart kept during the student's entire stay in the school. Prophylactic typhoid and diphtheria treatments are also given.

Living conditions are a matter of greatest importance to the health of the student. The home is located sufficiently near the hospital for convenience and far enough removed to give relief from the atmosphere of restraint and sickness. Separate rooms with comfortable beds and adequate bath and shower facilities are necessary for the well-being of the individual. Attractive reception and living rooms with piano, radio and victrola provide the needed facilities for entertainment. A library well stocked with reference books and fiction and with current magazines of varied interests makes possible any reading for pleasure or progress.

The food must be well balanced, appetizing and be selected upon the basis of its palatability as well as its proper caloric value. Milk is served at all meals and for mid-morning nourishment. According to the doctor's directions, students are placed on special diets—basic, vegetable, anti-constipation, reducing or increasing weight. For the nurse who needs the latter, we prescribe cod-liver oil or pancreatin tablets, if the condition indicates the need. This close supervision gives the student a definite idea of a balanced, varied and appetizing diet and of the special diets most required by the public.

Recreation Promotes Health

Recreation forms a most important place in maintaining happiness and in promoting health. By location, we are fortunate in having an environment that encourages outdoor exercise and sports. A park with tennis courts and outdoor picnic facilities lies within three blocks. The ocean with an ideal bathing beach to which street cars passing the door lead, tempts those who like swimming and beach picnics. Charming trails make hiking or horseback riding attractive for those who like these forms of exercise. Indoor activities are encouraged mostly by the student body association, which meets twice a month. The students are given help and encouragement in all their endeavors by advisory members of the board, as well as by hospital and school of nursing officers.

A vacation and rest home has been provided by one of



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the members of the board, where nurses and students alike can convalesce and go for a vacation or week-end parties. As this is in the mountains, it gives a pleasant change in altitude and environment. Days off are so planned that the most congenial groups can be sent together. Not the least valuable feature of this is the opportunity for faculty and students to meet in a social atmosphere, and the acquaintance so made helps each to a better understanding and appreciation of the other as a human being and fellow creature.

The mental attitude of the student is another important consideration, if she is to be of help to others in attaining health. She, herself, must have a sane philosophy and a sound basis of common sense. From the day of her entrance to the school, every effort is made to develop her personality and individuality and to prepare her to fit in with the social life of the world.

Big Sisters Welcome Arrivals

In the first few weeks there is not much opportunity for her to show her capabilities as to initiative and executive ability, but these qualities, too, are to be kept in mind and encouraged. Every effort is made to see that her first impressions are good. We try to make her feel that she is coming to a wholesome, normal atmosphere where she can expect kindness and helpfulness from other students and the school officers. The first step to this end is attained by having a big sister appointed by the president of the student body association. The big sister has already written to the incoming student and is informed of her arrival so that she welcomes her and furnishes her any information that will be helpful in making her adjustments to the new surroundings.

Early in the course the new class is given a series of talks by the director of nursing who discusses the various problems the students will most probably meet in their relations with other nurses, patients, staff, executives and employees, so that the nurses may be mentally prepared and put at ease. They are also given an individual intelligence test by an expert psychologist, who points out to the student her good points upon which to build and her poorer points upon which to labor for improvement or elimination. Her report is a helpful guide to the supervisors in understanding the student and in directing her.

Another decided factor in establishing a proper mental attitude is the balanced course of study and nursing practice. The preparatory period, giving a basic course of instruction, relieves the congestion of class work later in the course, when the student carries a heavier tax on her nervous and mental strength. The thorough training in the practice of nursing procedures establishes her self-confidence and she goes to her bedside practice with assurance that she is ready to meet the responsibilities placed upon her. This same course is pursued in planning her nursing practice: she is prepared for responsibility and then it is placed upon her as early as possible.

Through the course in personal hygiene she is taught the proper care of her own body and encouraged to pass this instruction on to her patients. She is imbued with the idea that she is a teacher of health and that she has the opportunity to teach in her work at the bedside, her contact with mothers, employees of the institution and visitors to the patients.

During this course, each student keeps a chart of her own health habits. The first lesson or two includes a discussion in a general way of such questions as bathing, outdoor exercise, drinking water, eating between meals, sleep and recreation. The students decide how these questions should apply to the nurse, and then proceed to record in

chart form their own habits. The results, discussed in class from week to week, have really been a revelation. During the spring, while our last course was in progress, these charts served as a stimulus for hiking, tennis games and swimming. Also, the amount of water consumed for drinking purposes increased somewhat, as each student tried to total six or eight glasses a day.

In our hygiene course we include a series of four lectures by one of our women physicians. In a remarkably fine way she presents the subject of sex hygiene, explaining to the students what is the normal relationship between the two sexes, and discusses with them various problems that are apt to arise. Also, she covers the questions of social hygiene with all of its various complications. The students are most enthusiastic over these lectures, feeling that they help them both personally and in their ever-present role of teacher.

Later in the training comes the course in public sanitation, which applies to the community many of the rules learned for the individual. As much as possible, we arrange trips, enabling the student to learn first-hand the handling of milk, purification of water and system of sewage found in our city.

The health of other hospital employees is cared for in much the same way, except for the classroom instruction, as that of student nurses. Results are not so satisfactory, because of the more frequent changes in personnel and because of the less responsive type of individuals.

Next we shall consider the application of the principles of positive health in the hospital itself. Great effort is made to maintain the atmosphere of a hotel in which guests are expected to have as much pleasure as is compatible with their own physical condition and still not cause annoyance or discomfort to others not so far on the road to recovery.

Informal Atmosphere Attained

In construction the building carries out the idea of small, homelike units. Furniture and furnishings are selected with more attention to attractive appearance and comfort than to sanitary cleanliness. Beds are of the wheeled variety and are taken out to the open porches, of which we have many, as often as possible. This is especially true of the children. The individual preferences of the patient are given more emphasis than the orderly arrangement of furniture, shades, standard equipment. This, to some extent, sacrifices the efficiency and convenience gained by standardization and often gives the appearance of confusion, but it is a gain in comfort and contentment. Sometimes it is a little difficult to make adjustments between the radio fan who is getting a good jazz orchestra on the air, the victrola enthusiast enjoying Galli-Curci, and the tired, nerve-racked individual whose "diet is getting adjusted" and who needs rest and quiet as well. Usually it can be done and is always well worth the effort.

The medical director and the interns, in making rounds, often obtain information that is a guide to them in giving advice to the patients in maintaining health after leaving the hospital. Often, too, they learn of some social condition that can be helped by the cooperation of the social agencies with which we keep in touch, and so relieve a worry in the mind of the patient.

This brings us to the out-patient department, which offers an unsurpassed opportunity for teaching the fundamentals of right living. As this is given by especially prepared nurses and social workers, the student nurse privileged to have service in this department has occasion to see the home problems of her hospital patient and to



The Beth Israel Hospital, New York City, now in process of construction. Plumbing fixtures, valves and fittings supplied by Crane. General Contractors, G. Richard Davis Co. Plumbing Contractor, Jarcho Bros. Architect, Louis Allen Abramson. Consulting Engineer, A. E. Hanson. Superintendent, L. J. Frank.

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Day by day, month by month, hospital facilities are being improved. New equipment, better serving the needs of medicine and surgery, embodying the latest improvements in sanitation, is installed. Entire new buildings, meeting the most exacting modern requirements, are being erected. More hospitals are being organized, to fill the growing demand for hospital treatment. In such building, nothing

is receiving more careful attention from medical and hospital authorities than the plumbing fixtures, valves and fittings upon which proper sanitation primarily depends. This care is one reason why the list of Crane-equipped hospitals becomes more and more a roster of the finest hospitals in America. See the display at the Crane National Exhibit Rooms, 2401 Boardwalk, while attending the Atlantic City convention.

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broaden her sympathies and interests. She can see herself becoming a unit in civic life and sense the possibilities of her influence and responsibility. These must be pointed out to her, and not left for her to absorb only what she can get by herself. The teaching she hears given in the baby conferences, prenatal child welfare and orthopedic clinics, furnishes material all of which is useful in her later contact with the public.

The obstetrical department is able to do much for its patients while under its care. While still in bed the patient takes exercises for strengthening the abdominal muscles and for securing normal pelvic conditions. She is given instruction about continuing these exercises and in the care of her breasts, after she leaves the hospital. She is given a demonstration of the baby's bath and advice for the child's care and training. When she leaves she is given a form of printed instructions as to the baby's immediate care and is told to call upon the hospital for advice at any time. The supervisor keeps a card index of her patients showing day of month when each patient enters the hospital. If the mother has not called in by the third day, which she usually has, the supervisor calls her and gets a report of the condition of both mother and child. She repeats this at definite intervals, two weeks, two months and six months, keeping a record on her card of any matter of interest. This forms a closer bond between the public and the hospital and encourages and helps young mothers in the right care of their families.

Another form of health instruction which has been carried on in our institution has proved to be most satisfactory. For the past four years, Dr. W. D. Sansum, who is in charge of the metabolic department of medicine, has conducted a series of lectures on normal diet. In the beginning, there were three and the course was repeated once in three weeks. Now six lectures are given every alternate week. They are well attended by the public, by Dr. Sansum's patients in the hospital, and by the student nurses who are having their service in the dietetic department at that time. To the latter they are most valuable as instruction in presenting the problem of food to the public. The subjects included are the caloric, protein, bulk, mineral, water and vitamin requirements of the body, and acidosis. The audience varies in age from seven to seventy years, and the lectures are made interesting and understandable to all. So great has been the success of this phase of health instruction that an extensive program has been arranged by the superintendent of the hospital to have similar teaching in other subjects.

Plan Series of Public Lectures

The plan is sanctioned by the board of directors, the medical director and the president of the county medical association. It has received the heartiest approval of the staff, which has agreed to cooperate in every way. Individual members will give the lectures each in his specialty. The entire course is to be advertised in the beginning and each group of the series prior to the week of its commencement. This will be done in the newspapers and in a monthly hospital bulletin sent to local people.

There will be about seventy-five lectures on twenty subjects. These will be handled from the standpoint of prophylaxis and the recognition of early symptoms rather than as a discussion of disease. For example, in obstetrics the lectures will cover prenatal instruction to expectant mothers; care of the mother and child during and immediately after confinement and the after-care of the child. This will be followed by talks by a pediatrician on the general care and feeding of young children, child management, prevention of contagious disease and nervous

disorders of childhood. Other medical and surgical conditions will be handled in the same way, always with the idea uppermost of teaching prevention and normal right living.

It is felt that with anything like the response from the public that has been received in the course of food lectures, a tremendous amount of good will result.

In summarizing, I shall mention the principal points of progress we have made in placing health on our school of nursing program. The health of the student nurses; the general atmosphere of the hospital; the attention to patients from the positive health standpoint; formal course of instruction to patients and public; formal instruction in personal, mental and social hygiene.

In the course of the formal instruction the advantage of a good course in psychology is recognized, but for want of the right person to give it this teaching has not yet been used.

We have only made a beginning in this most important field of hospital activity. We hope to make of each student a teacher of positive health and to send out each patient improved in health and with instruction that will enable him to help himself and his community to more healthful living.

WHAT MY DIPLOMA MEANS TO ME

By Lois Showalter, City Hospital School of Nursing,
Welfare Island, New York

Always there is a certain amount of joy and satisfaction in accomplishment. At first thought, my diploma means that I have reached my first professional goal. The years of inexperience accompanied by determination and effort have been crowned with the stamp of approval of the school I chose and love.

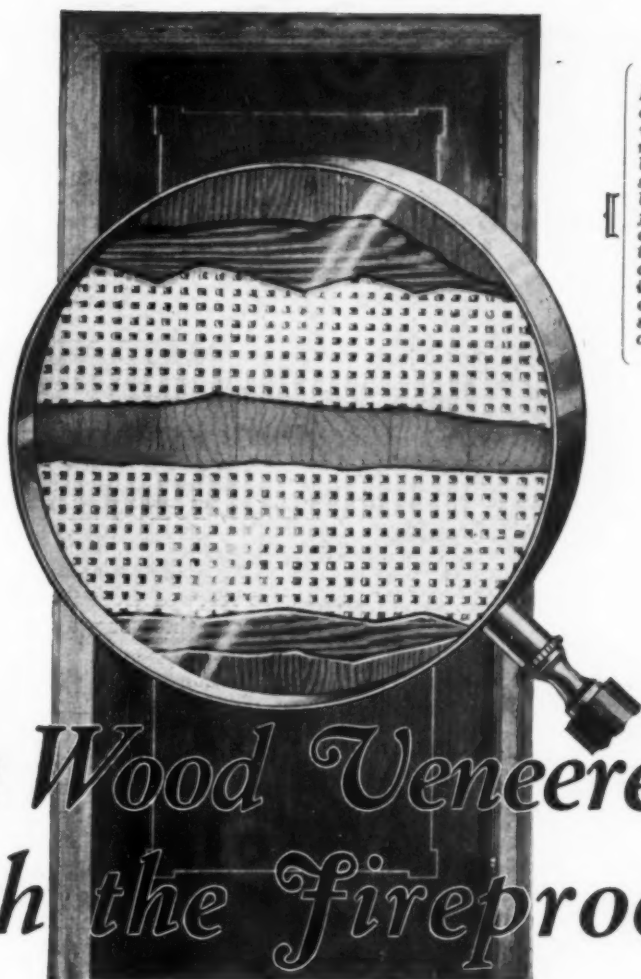
My diploma means an added feeling of responsibility and obligation. Away from the protected, guided shelter of my training school, I stand alone and yet not alone. I am taking my place in the ranks of one of the most ancient and honorable vocations, a vocation of inspiring example, splendid traditions, marvelous undeveloped possibilities and deep human need. I shall have the opportunity to help to "carry on" in our beloved profession. With the presentation of my diploma, I am intrusted with the most valuable thing in the world. A human life in need looks to me for help. The public recognizes a graduate nurse as one who can give skilled service to the sick and helpless.

My diploma means more self-respect and honor from the standpoint of being self-supporting. With many of us the mercenary spirit has a tendency to predominate. The glitter of fine clothes and luxuries that have not been possible during our days of training are apt to overshadow the gold of real service.

A triumph of the nursing spirit is represented by my diploma. Through hard, struggling years the modern schools of nursing have evolved. They yearly send out hundreds of young women who stand for self-sacrifice and service as well as for the science and art of nursing.

Finally my diploma gives me a strong feeling of sisterhood. An intense feeling of loyalty, devotion, pride and courage bind our profession closely together in attaining our common goal of positive health.

During 1922, the last year for which complete data is available, there were 78,070 persons cared for in almshouses in the United States and 348,174 treated in institutions for the insane.



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OUT-PATIENT SERVICE

Conducted by MICHAEL M. DAVIS, Ph.D., Executive Secretary, Committee on Dispensary Development, United Hospital Fund of New York, 15 W. 43rd Street, New York
and by ALEC N. THOMSON, M.D., Medical Secretary, Committee on Dispensary Development, United Hospital Fund of New York, 15 W. 43rd Street, New York

MEETING CLINIC NEEDS IN A SOUTHERN CITY

By S. Lucie Wallace, Director of Social Service, Touro Infirmary,
New Orleans, La.

TOURO Infirmary was founded in 1868, in accordance with the provision of the will of the late philanthropist, Judah Touro, to care for the indigent sick of the Jewish faith. As it has grown in response to the demands of the community for its services, it has become absolutely non-sectarian in its work. Although it is still directed and sponsored by a Jewish board, over 95 per cent of its patients are not Jewish.

The institution is provided with the latest modern hospital equipment. Its facilities for in-patients consist of 403 beds, one hundred of which are free and fifty-six part pay. The out-patient department averages 350 visits daily. There is no city or state limit to the patients admitted for treatment either in the ward or the out-patient department. Patients are drawn from all over the south, especially from Texas, Alabama, Mississippi, and Louisiana. Although there are no ward facilities for colored patients, they are treated in the out-patient department. The strategic geographic position of Touro Infirmary, its broad policies regarding admission and its relationship with Tulane University, New Orleans, combine to make its influence far reaching.

Problems of Out-of-Town Patients

So many problems are presented by patients sent from out of town that the social service department is attempting, as part of its program, educational work regarding admissions and after care. This is a difficult task, since few of the communities have organized agencies with which to work, and the work must be done through doctors, coroners, police juries, whatever organization the state has, or interested individuals. Where there is a public health nurse or a health unit these services have been indispensable. Improvement in the work is gradual, and the best we can ask for at present is notification in advance that a patient is to be admitted and some history of the illness. Then we obtain through friendly co-operation a simple picture of the home and an idea of the after care possible for the patient.

The out-patient department is an integral part of the hospital. Two years ago, when the annex was built, the department was moved into new quarters and a reorganization of administrative procedure was instituted. The five fundamental standards of out-patient service endorsed by the Associated Out-Patient Clinics of New York have been in effect at the infirmary for a number of years, but during its reorganization many further helpful sug-

gestions were received from the Committee on Dispensary Development, and these suggestions have been worked out most satisfactorily.

The organization of the out-patient department and ward service differs somewhat from that of the average hospital in that the director of social service is not only in charge of the social work in the out-patient department and the wards, but is also administrative director of the out-patient department and has control of the beds in the free wards, as all admissions to the wards are made through social service. This person is directly responsible to the superintendent of the hospital. We believe that this is a good organization and that it makes possible continuity of service, since every patient admitted to either the out-patient department or the wards is potentially a social service case and is treated as such. This method of organization centralizes all activities and promotes smoothness in interpretation of policies and prompt action on any matter generally involving two separate departments.

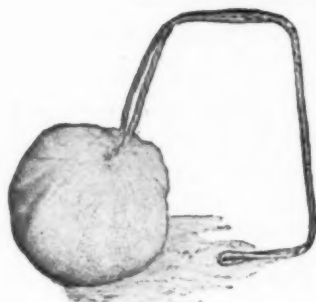
The average number of individuals treated daily in the out-patient department is about 350. A registration fee of fifty cents is charged on the first visit and twenty-five cent service fee for each subsequent visit. Small nominal fees are also charged for x-rays. Medicines are dispensed at cost from the out-patient pharmacy. All or part of the fee, including medicines, is remitted upon the recommendation of the social service department. No material relief other than medical is given, but the out-patient department assumes full medical responsibility for its patients and considers as part of this responsibility supplying of spectacles and orthopedic or other appliances to those patients unable to afford them. In the majority of cases, however, the patient eventually reimburses the institution for these appliances. No special pressure is used to bring this about, but they are permitted to pay, through the social service department, a little at a time as they feel able.

Smooth Admission System

The admission problem has been carefully studied, and the present system is working smoothly. New and old patients are separated at the door; the old patient shows his identification card to a clerk who gives him a ticket serially numbered for the particular clinic he wishes to attend, notes on a slip of paper the record number from the identification card and transmits this to the record

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(No. 1)

1. Adenoid-Tonsil Tampon

is made of lamb's wool stuffed in a doubled gauze casing, raw edges turned in with minimum bulk. As it is entirely a hand labor problem, many valuable nurse-hours are saved by buying this perfectly-made article already prepared.

In practice it is regarded as the most effective means of hemostasis in both adenoid and tonsil operations.

It is not to be confused with the ordinary (absorbent) gauze tonsil sponge, for this wool tampon is practically non-absorbent but resilient. Its function is to maintain a pressure hemostasis in the nasopharynx or tonsillar fossa.

There are two sizes, Adults and Childrens, packed in bulk, 100 of a size in a box. Detailed literature available.

2. K-Y Lubricating Jelly (Hospital Size)

Hospital superintendents familiar with this "cleanest of lubricants" will be glad to know that it is now obtainable in a LARGE



(No. 2)



(No. 3)

3. Baby Identification Strip

This simple, inexpensive device is sanitary, convenient and positive. The arrangement of the adhesive plaster is such that there can be no irritation; only a soft downy material touches the tender infant skin.

This strip never falls off, cuts or irritates, and mothers cannot object to its use.

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- ☐ Baby Identification Strip

Hospital

City

State

vault by messenger. The record is then sent to the clinic. (It is eventually planned to use a telautograph for transmitting the record number to the record vault.) From the admitting clerk, the old patient passes to the cashier's desk where he pays his service fee, or has his ticket stamped "no charge" and then goes to his clinic. This line passes very quickly; there is rarely any congestion.

The admission of new patients is always a slower process. Each new patient is given a ticket serially numbered, and an application for admission is filled out by a clerk giving the identifying information of the patient and his family. This is cleared on the Russell index before the patient is admitted and if there is a previous record of the patient a new one is not made. This step has avoided numerous duplications of records. After the name has been cleared the patient is seen by the admitting physician, one of the hospital interns, who takes the complaint, makes the medical placement, and stamps the name of the clinic indicated on the patient's ticket.

physical examination, measurements and laboratory work on the first visit and report every two weeks for observation, blood pressure and urinalysis until the seventh month, then every week until delivery.

After the first visit to the clinic the social worker calls at the home to make a general investigation and determines facilities for delivery in the home. There are two nurses in attendance for outside deliveries. All white primiparas are delivered in the hospital and multiparas at home, unless the medical condition indicates need of hospital treatment or the home is inadequate for the delivery. The first condition is determined by the doctor, the second by the social worker.

Where hospital treatment is necessary for colored patients they are referred through social service to a private colored hospital in the city and the expenses met by the infirmary, the patient paying what she can towards this. Each new patient is also registered for prenatal class instruction. The class meets each week and the course



Touro Infirmary, New Orleans, La. The out-patient department is located on the first floor of the building on the left.

A social worker next interviews the patient, particularly with respect to financial status, to determine eligibility for clinic care and if accepted, his clinic status, that is, if he is a pay, temporarily no charge, or fee patient. (Different colored cards denote this status.) The patient is then sent to the clinic assigned. The record is typed and sent to the clinic, and the index card is also typed at the same time. In this first interview the social worker makes note of any outstanding problems presented by the patient and passes it on to the social worker in the clinic. The new patients are registered daily with the Confidential Exchange and a place is provided on the social service history form for the return information from the exchange.

Clinic Records Centrally Filed

Touro has a central filing system for all clinic records, and the social record is also filed with the medical one, except in intensive cases when a summary of the case is placed in the medical record. This social service sheet is a part of the medical record and all static information is kept there. It is taken only once when the patient is first admitted. Addresses and other necessary data are checked by the clinic secretary and kept up to date on the one form. A uniform medical history sheet is used by all clinics and the treatments recorded chronologically. A special consultation sheet and a laboratory sheet are provided in the record.

The maternity and new-born service is an interesting development and is a good example of medical follow-up and interrelation of two clinics. In the maternity service patients are encouraged to come to the clinic as soon as they know they are pregnant. They are given the usual

consists of five lectures: the first on the meaning and need of prenatal care, given by a doctor; the second on the diet of the pregnant mother, given by the hospital dietitian; the third on the clothes for the pregnant mother and the baby, given by a lay volunteer; the fourth on the preparation for the delivery at home and a demonstration of the baby's bath, given by the nurse in charge of the obstetrical department of the hospital, and the fifth on the after care for the mother and the baby. This last lecture is divided, the first part given by the chief of the obstetrical department, the second by the chief of the pediatric department who paves the way for the new-born clinic.

A close follow-up is kept on all prenatal cases. When a patient fails to report on an expected date, a follow-up card is sent, giving another date. If the patient does not report on this date she is reminded by letter. If this does not bring her, a visit is made by the social worker. (This is the general follow-up procedure throughout the clinic.)

After the delivery, a card is given the patient telling her to report to the maternity clinic for herself and to the pediatric clinic with her baby on the Thursday nearest the date when her baby is a month old. The new-born group is thus divided into four classes corresponding to the four Thursdays of the month. The card is given by the social worker to the hospital patient on the day she leaves there; by the nurse on her last visit to the patient delivered at home. When the mother reports to the maternity clinic for postpartum examination, she is generally discharged unless her condition indicates that further treatment is necessary. She is not discharged, how-

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ever, until the social worker in the maternity clinic sees that she reports with the baby to the pediatric clinic. All social data is then transferred to the social worker in the pediatric clinic who assumes the case.

The baby reports to the new-born clinic once a month until he is a year old. The clinic routine is carefully worked out and generally between eighty and a hundred babies are seen during the morning. Weights and temperatures are taken by a nurse, feeding history by a volunteer, physical examination by a doctor, and special examination for rickets study by another doctor. Each child is then seen by the chief of the pediatric department who reads the summary of all previous examinations and makes recommendations regarding diet and other matters. A close follow-up is also kept on these patients by the social worker.

Clinic for Preschool Class

After the child has been in the new-born clinic for a year, he is graduated to the Tuesday preschool class which reports four times a year for examination and laboratory work. When the child enters school he is transferred to the school class. The children in this group are examined twice a year on Saturdays. By the time the child has been in the school class several years and is old enough to be transferred to the adult clinic (age, thirteen), we hope he will be educated sufficiently to realize the need of a health examination once a year.

The actual case work in the clinic is limited because the case workers (only five in number) are unable to handle all the cases that need social service. We are conscious of this need, however, and as soon as our finances permit we shall increase the staff. At present we have one person for the children's work and one for adult work, except for maternity and genito-urinary (this includes all the venereal disease group). To each of these clinics special workers are assigned. The fifth worker has charge of the ward work. The social worker who has the first interview at the admission desk is not considered in this group because her work is entirely financial investigation. She does not attempt any case work. Arrangements have also been made for the addition in the near future of a general supervisor of case work, who will coordinate and supervise all the case work in the out-patient department. While this is an absolutely minimum staff of case workers, we feel that a maximum use is made of their time. Our organization provides for a paid secretary in each clinic who does all the clerical work which, in many clinics, is the responsibility of the social worker and the volunteers. The social worker is thus relieved of all routine so that full time can be devoted to social work.

The majority of our cases are in the slight service group. Only a limited number of intensive cases are attempted. A great deal of "steering" work is done with other organizations. We were the first organization in New Orleans to use a "steering" blank for the transmission of information regarding patients referred for treatment, and for the return report. We hope this will come into more general use and that a standard form will be adopted by all the agencies. Several children's institutions send all the children to this clinic for general physical and mental examinations and laboratory work before they are admitted to the institution. The Louisiana Society for the Prevention of Cruelty to Children also follows this plan with all their cases before placement. Other organizations in the city use our out-patient department for examinations and for obtaining the doctors' opinions as a basis of social planning.

Both clinics and wards are used as teaching centers for

the senior students of Tulane University Medical College. During the past year there has been an arrangement with the Tulane University extension department for training for social work and Touro Infirmary social service department, to take its students for field work. This has been somewhat of an experiment, because the other organizations are not able at present to take the students in this way. They have, therefore, been doing all their case work at the infirmary, with, however, the fullest cooperation of the other organizations and through a special arrangement with them, they have been able to serve the patients in the capacity of family worker, and children's worker, as well as medical worker. Geographically, New Orleans should be the leader in the development of medical and social work in this part of the South, and we plan to have Touro Infirmary take her part and responsibility in this leadership.

We have thirty-six regular volunteers whose splendid spirit and faithful service are a source of pride. For the most part they assist the clinic secretaries in clerical work and in carrying out routine procedures. Some of them are assigned to aid the social workers by running errands or doing other time consuming but necessary odd jobs. The Junior League of New Orleans has interested itself in our obstetrical and new-born clinics. As their share in the work, they have offered four fellowships at Tulane University, two in obstetrics and two in pediatrics. The fellows work at Touro in the wards and clinics of these two departments, and the Junior League members volunteer in these two clinics as clerical assistants.

We feel that the out-patient department has a big opportunity to give real service to its individual patients and the community at large. Most of our social work is pioneer work and with such a field our scope is unlimited. Our development in volume has been progressive and more rapid than we would have liked it to be, but we have always conceived it our duty to respond to the demands of our community for service. Our goal is set at a high standard of work, but we sincerely hope never to permit ourselves the destructive luxury of thinking that we have attained the goal.

THE MESSAGE OF THE GRAPH

We are living in the picture age. Nothing more ably conveys a message or gets over an idea, than a picture. Graphs are statistical pictures. They are pictures showing the trend of performance or costs, and are immensely more effective than bare figures. There is no more conclusive argument than the presentation of a true picture of the performance of any one department. Let a dietitian, for instance, be shown a graph, in which her labor costs, her food costs, her breakage, and other factors, are seen to be mounting higher than is warranted by the prevailing prices or activities and she has before her a picture that permits of no alibis, excuses or arguments.

DANVILLE TREATS 2,701 NEW PATIENTS IN FIVE YEARS

Since August 17, 1920, the eight clinics of the Danville, Pa., State Hospital, besides supervising the patients furloughed from Danville, have seen 2,701 new patients, men, women and children, with mental problems, who never had passed through the hospital mill; many of them, thanks to early treatment, have thus avoided it. About 60 per cent of these new patients were children. During the past year of 1925 the clinics recorded 1,741 patients. —Mary Ross, *The Survey*.

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DIETETICS AND INSTITUTIONAL FOOD SERVICE

Conducted by LULU G. GRAVES, 7 East 54th Street, New York
and MARY A. FOLEY, Director of Dietetics, Kahler Hospital, Rochester, Minn.

SOUP THE STANDARD DIET IN ALL COUNTRIES

By Rhoda A. Tyler, Dietitian, Grasslands Hospital,
Valhalla, N. Y.

IT IS often proved that we are quite apt to know the least about the things that are the most common in our everyday life. Take, for instance, the familiar dish served daily in most families, the soup. Indeed, family life in all ages and in all countries seems to radiate from the soup kettle. The effect is strangely visible in the growth of the young, the health of the aged, and the habits of the humble and the aristocrat.

This simple article of food has regulated phases of the court customs of kings, and has carried on the names of war generals and nobles. In connection with the last mentioned are consommé Colbert and the red bean à la Conde. During the reign of Louis XIV, the latter became internationally famous for inventing the bean soup as an addition to the army rations of France.

The Foundation of Soup

The foundation of soups are stocks, either white or brown, and are made of meat or fish. Soups are also prepared from vegetables or cereals, which have been cooked, strained and served as a puree or gruel. Milk or cream lends variety and an increase in nourishment. Some countries use fruit as a foundation of soups. These are served either hot or cold and are seasoned with sugar, spices, or blended with wine or beer. Fish soups are more common in the north and south of Europe and in Norway and Sweden, or the countries bordering on the Mediterranean Sea. In America, a clear soup, either a bouillon or consommé, is served at the beginning of a dinner. It stimulates the gastric juice and improves the appetite. The peasants of Europe serve a "soup plus" as a one-piece dinner. This soup is highly nutritious.

The soup, when served to the invalid as a broth, bouillon or consommé, invigorates the patient. Perhaps we may allegorically call it the liquid span that bridges the abyss called illness and starts the individual on the highroad to health.

There are times and occasions, however, when soup is not eulogized. The college youth, probably from time immemorial, has ridiculed and scorned the consommé, notwithstanding the scientific name that designates it on the menu card.

We have previously called attention to the fact that certain soups are of international importance. With this idea in mind, let us consider some specific soups associated with popular customs of particular countries. Some of these dishes will have a relation to ancient customs, while

still others that do not may prevail at the present time.

The most ancient mention of soup we find in the Bible depicted the family life of Jacob and Esau, who sold his birthright for a mess of pottage. Among the customs of the Jewish people we note in the preparation of meat they still follow the traditional laws laid down for the Israelites. In modern English it is called "kosher" meat. The animals are killed by a specially ordained parson, usually a priest who also removes the veins and sinews. It is koshered by removing the blood, and the meat is soaked and rinsed, then salted and thoroughly washed before using. Pork is not allowed because, according to biblical tradition, the kine¹ must split the hoof and chew the cud.

During the Jewish Pesach or Passover, observed for eight days in the early spring, the soups, in fact all foods, are prepared in special utensils kept sacred for these nine days of lamentation. Meat and milk or meat and butter are not permitted to be cooked in the same utensils.

The Passover bortsch is prepared similar to the Russian borstch mentioned later. Instead of the sour milk used by the Russians, a specially prepared beet vinegar is used. A yonzor soup is made from beef and chicken with vegetable. This butter soup was among recipes used during Passover week. The foundation was fresh green peas; to these were added young turnips and carrots, parsley, onion and cauliflower; the vegetables were cut in small pieces. The soup was seasoned with pepper, ginger, mace and a good sized lump of butter. These simmer together then, before serving, unleaven dumplings were dropped into the hot soup and cooked for fifteen minutes. (No leaven is used during the week of lamentation.) In a Palestine soup one finds the Jerusalem artichoke as the chief feature. To this is added onion, parsley, chervil, celery and garlic.

How Sour Milk Is Used

The sour milk soup is an entity of itself. The jellied (clabbered) milk is heated one minute in a sauce pan. It is then thickened with flour, strained and served and sprinkled with maple sugar.

A special stew for the week is a fricassee of veal with cauliflower. The veal is cut in pieces, onion and tomato are added, and just before serving it is slightly thickened with flour. It is served on a platter with the cauliflower divided and placed around the stew.

1. Deut. 14-6.



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When these things are considered, it is only natural that so many hospitals of the type pictured on this page should use Clow plumbing throughout. The same assurance of fit, appearance, operation and long life holds true, no matter in what department the installations are made — kitchen, laundry, toilet or therapeutic room.



Clow laboratory sink built to meet special requirements.

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CLOW

PREFERRED FOR EXACTING PLUMBING SINCE 1878

A cold sour soup, for use during Passover week, is prepared in advance from sorrel, potatoes and onion, thickened with eggs. This is always eaten cold and is kept from two to three weeks.

It is interesting to note that the Chinese method of cooking was invented in 3000 B. C. by the Emperor Pow Hay Se. The science of eating is credited to the philosophy of Confucius, who recommended that the parts of soup should be in the proportion of one part meat to two parts of the vegetables. He advised having all food chopped and delicately flavored with ginger. There are three parts to a Chinese dish, the primary, secondary and garnish. The primary soup is always made of equal parts of chicken and pork. A bowl of chicken blood is added to the mixture "to do away with any oil." The secondary vegetables are water chestnuts, bamboo shoots, celery or Chinese mushrooms. The meat and vegetables are cut of equal size, forcemeat balls are used as a garnish and a few drops of sesame oil are added for flavor.

Birds' Nest Soup Recipe

Birds'-nests soups are synonymous with the Chinese. These swallow nests are found on the rocks in the caves along the sea coasts, especially the island of Java. The nests resemble shells and are formed of a transparent yellow material. They are carefully cleaned, the dirt is removed with a coarse needle, and they are then used as a garnish for a rich consommé. In New York City the soup is served in a bain-marie. One-half a nest is allowed for each person.

Among the Chinese recipes are noodle soup and almond chicken, the latter comprising almonds, onions, water chestnuts, mushrooms and celery. The pineapple chicken soup includes, besides the two mentioned foods, green peppers, celery, sour ginger, vinegar and fun wine, and the mixture is thickened with eggs. We read that rat soup in China is considered on a par with the oxtail soup of England.

The chop suey of China has for its foundation some kind of a meat, as duck, chicken, lamb or pork, which is cut in small pieces and cooked with bean sprouts and onion threads, and upon especial occasions bamboo shoots and mushrooms are included. This dish is served with boiled rice and is to the Chinese what the Irish stew is to the people of Ireland.

The Japanese customs in eating are similar to the Chinese. The beche de me soup of Japan is prepared from the beche. This is a small animal caught in the Japanese Sea. After it is caught it is dried and when thoroughly cooked yields a gelatinous mass that is added to a savory soup.

The oriental soups are not so different as one would expect. An unusual one is a tripe soup. Tripe is chopped fine, then boiled in broth with chick peas and garlic. A dressing is added, which is made of eggs, lemon juice and wheat starch. In the lentil soup of the Orient the lentils are cooked in broth with onions; the soup is then strained and seasoned with pepper and salt.

Matzoun soup is made with curdled or fermented milk. Rice or some other starches are cooked together with onions and seasoning. A butter dressing and milk are added. Sometimes mint enhances the flavor.

Imrik, from which imrik soup is made, is a cereal similar to our cream of wheat. The dry cereal is fried in butter, then broth is added. When sufficiently thickened, it is seasoned to taste. Tarhana, a cereal also used in soups, is prepared by pounding and cracking wheat, then coating it with a mixture of sour milk and a heavy flour paste.

Cucumbers play an important part in the soups of Greece and Turkey. On All Souls' Eve, it is customary

to put coleva (All Souls' broth) on the graves of the departed.

A soup generally made for public rejoicing, as marriages or births, is made from mutton cut as small as walnuts, and then simmered until tender in a large amount of water. It is first thickened with a flour paste, then removed from the fire. In another sauce pan several eggs are beaten with wine, vinegar or lemon juice. They are then put over a fire until slightly cooked when they are slowly blended with the meat soup. Many Turkish soups are thickened with eggs.

The Orient has copied the consommé of France. The garnishes reflect something of the country tastes as, for instance, consommé Africa, as given in Filippini's "International Soups," and has an addition of diced egg plant, dried red pepper and curry powder. In Algeria, tapioca and egg plant garnish the clear soups. While not of the Orient, in Milanese consommé, we detect parmesan cheese, spaghetti, egg yolk and cream, spiced with cinnamon.

As the chop suey is associated with the Chinese, so the Pilaff is significant of Turkey. The meat of ham, chicken, lamb or veal is cut into dice and cooked in broth. It is then seasoned with salt, red pepper and saffron. Boiled rice and sultana raisins are added or served with it.

It was from the East Indies that the English copied the mulligatawny soup, a chicken soup highly seasoned with curry powder. The peppercorn of India is a Julienne soup, to which have been added dice of pickled pork and fowls or the meat of the crab. The curried meats are the characteristic stews of India. Apples and various vegetables are used in preparation; also the Indian chutney.

The Russian bortsch (soup) is made from beet root. Krass, which is a non-alcoholic Russian national drink, is the basis of good bortsch. It is made from bread, fruit or vegetables and is used by all classes. It is said to be healthy and nutritious when made of bread, and refreshing when made of fruit, which makes it similar to our cider or sherry. The beetroot krass used in cooking is a process of fermentation which is carried on for two weeks. It will then keep all winter if the water is kept constant. Surovets is prepared from dried buckwheat bread, water and yeast. Surovets keeps all winter if water is added as it is used. The preparation of bortsch is peculiar to Russia. Three cups of beetroot krass and one cup of surovets and water are mixed and in this beef, fowl and a small rib of mutton are cooked. To this is added vegetables, as beetroot, carrots, celery, parsley, fennel, cabbage, potato, tomato and onion. Salt pork is used in place of butter. It is bound together with flour and egg yolk. Just before serving sour cream is blended with the soup.

Frozen Stchee of Siberia

Before the advent of railroads, and even yet in Siberia, it is the fashion to carry lumps of frozen stchee, sufficient to last the journey. This is the most popular of all Russian soups. At the stopping places it is heated. This soup is prepared in two different kettles. In the first, beef cut in pieces is browned with dried onion, carrots, celery and leeks. In the second kettle, chopped onions are browned in butter; to this cabbage is added and stewed for one hour. The contents of the two kettles are then mixed, potatoes are dropped in and it is cooked another hour. The meat is then removed and the remainder is frozen. Green stchee is prepared from spinach, sorrel, nettles and chion leaves. When cooked, they are strained, sour cream is added, also soda and thickening. It is garnished with eggs fried in bread crumbs. The stchee

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is a cabbage plus soup and is very popular with the Russian peasant.

The bergos is a stew of leftovers; a bouillon of salt meat with any cold meat, as roast beef, duck, game, fowl or pork, and sourkraut, onion, bread crumbs, small sausages. It is thickened with roux paste, then pickled mushrooms and gherkins are added to give flavor.

Poland has a slight variation of bortsch. In a bouillon are cooked vegetables such as onion, leeks, carrots, celery, beet roots, flavorings as parsley, dried laurel leaves and vinegar. It is thickened with roux paste, seasoned with salt and pepper; then frankfort sausage is added. Another Polish soup is cooked rice, sour cream and lemons, heated in meat stock. The meat is cut in pieces and served in the soup.

A Polish stew is sometimes made from a loin of beef stuffed with forcemeat. The meat is firmly tied, then browned in fat. It is simmered three or four hours with onion, carrots, celery and various herbs. Cooked tomatoes and cooked red cabbage sliced and dipped in vinegar are added before serving. The meat is placed on a platter, then the vegetables are poured around, and cooked onions and beets are used as a garnish.

Braumbier Suppe Mit Milche

The bier soup of Germany is a combination of beer, water, sugar and salt, potato flour and egg yolk. (Braumbier Suppe mit Milche.) Milk is added and the soup is flavored with stick cinnamon. A rose hip soup is made with dried rose hips, potato flour and sugar, to which little dumplings are added just before serving. A cherry soup is a favorite of North Germany. The sour red cherries are first stewed with lemon. They are then divided into three parts, one part is stoned and put into the soup whole; the other part boiled with water and flour, strained, when the cherry stones are pounded, heated in wine and strained. The two liquids are blended and served with the cherries as a garnish. Chicken or fowl is the basis of the soup a la Rhine. The meat, except the breasts, is pounded and added to the broth with grated almonds; cream and butter increase the richness of this dish.

The German chicken stew is very delicate, as almonds pounded into milk are added just before serving. It is seasoned with pepper, salt and nutmeg. From Baden Baden came a kidney stew, with chopped mushrooms and parsley, flavored with sherry, which was served with a border of fritters. The goulash of Hungary always contains three kinds of meat but seldom any vegetables; carrots are sometimes used.

The only unusual Dutch soup is an onion cream soup blended with egg yolks. Chopped pimento and grated Edam cheese give it a local color.

The minnestrome is the national dish of Italy. In this soup are blended bacon and ham, shredded cabbage, string beans, dried celery, peas, asparagus tips and stewed tomatoes, spaghetti, sliced bologna, and parmesan cheese. The consommé of Italy is served with parmesan paste made from equal parts of cheese and flour seasoned with salt and cayenne. For one cup of each, four eggs and one-half cup of cream or milk are used, which make a thin batter. When the soup is boiling the mixture is put through a coarse sieve. This makes long strings which should cook ten minutes.

Soup alla Nazionale is made from a rich stock that is garnished with queuelles colored, red and green, mingled with white ones, which are the national colors. Spinach or peas are used for green, tomatoes or lobster for red color. The queuelles are prepared from chicken or from

butter, flour and parmesan cheese; sometimes bread crumbs are combined with cheese and egg with nutmeg and salt for seasoning. While in Venice we found a rabbit stew, thickened with yolk of egg, and capers gave it a touch of green.

The Spanish soup, Olla Podrida, is cooked most of the day. Beef, chick peas, bacon and raw ham are cooked together for two hours. A fowl with vegetables, as carrots, onion, garlic, cloves, bay leaf and parsley are then put in and it is cooked two hours longer. After four hours cooking, smoked sausages and a head of cabbage, which has been previously blanched, are added and all are cooked two hours longer. A pinch of saffron is now soaked in water; after this has been cooked in the stew for one-half hour, it is served, sometimes as a one-piece dinner, or the liquid is strained out and served as a soup, and the meat and vegetables are arranged on a platter.

A rabbit stew in Spain is seasoned with herbs. Large oysters are put in just before serving. Other native dishes are the black bean soup, puchero, garberre. The pepper-pot of Portugal is a thick stew, highly seasoned.

France, more than any other European country, has won national and international fame for her economy and the excellence of her soups. It is said that everything goes into the soup stock. Mrs. Pennel writes that it is the soup that appeals to the traveler and makes traveling so easy and luxurious in France. Henry James was enthusiastic over his bowls of bouillon and in his "Little Tours of France" he describes it in rich verse.

Alexander Dumas, who was as noted for his knowledge of kitchen lore as for his novels, wrote, "French cuisine owes its superiority to the excellence of its bouillon, which is a product of a continuous simmering over a period of seven hours."

Pot au Feu the National Dish

The pot au feu (pot on the fire) is the national dish of the French family. It is a hearty dish and is made of broth, meat and vegetables. It is cooked in a covered earthen kettle known as pot au feu.

The potages are of two classes. Potage gras, made from meat stock, and potage maigres, prepared from vegetables. Potage crûte au pot is the name given to the leftover soup as it appears the second time. Bread is toasted or fried, then the soup with the vegetables is poured over, steaming hot. Grated cheeses usually accompany this appearance.

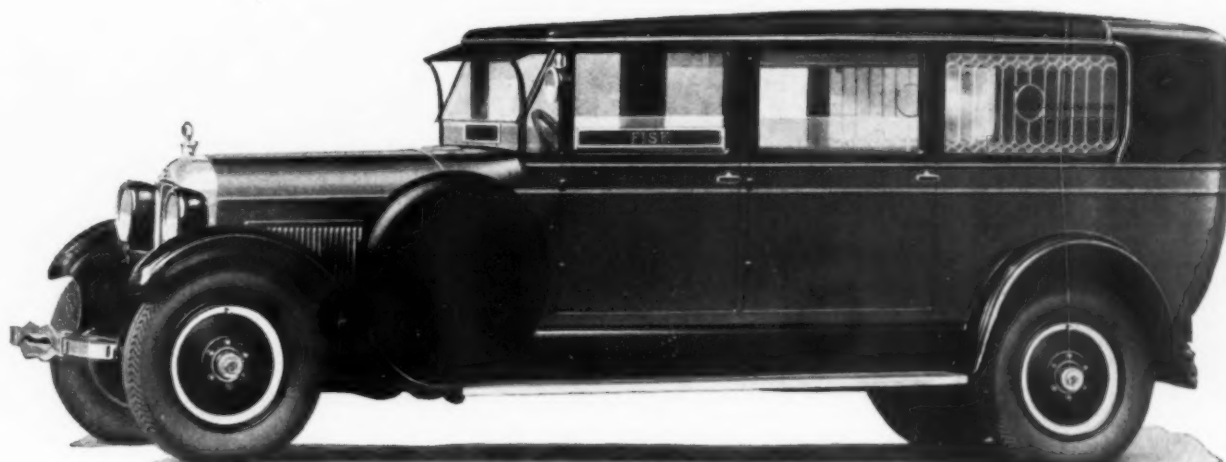
As we have previously stated, France, more than any other country, names food from chefs and men who were influential in their preparation, or from the locality in which they are popular.

We mentioned Consommé Colbert and Red Bean Soup à la Conde. There are others worthy of note, such as the Julienne soup. It was in 1785 that Jean Julienne, a famous chef, is said to have served a soup with vegetables cut in strips. Julienne vegetables in soups and stews are as popular now as they were in the eighteenth century.

A man by the name of Parmentier introduced the potato into France. This historical fact is constantly recalled by the potato soup, potage parmentier. Consommé Rachel was the favorite of a famous actress whose name it bears. A little town of Crêcy produced the finest quality of carrots in France; what could be more appropriate than to call the carrot soup potage à la Crêcy.

On the Isle of Bourbon snail soup is considered a great delicacy for the sick. The Marseilles bouille-a-baisse, a specialty of southern France, is prepared from fish caught in the Mediterranean Sea. Recipes call for one large fish and several small ones. Some of the fish used are flounder, whiting, sole, perch, red mullet, lobster and mussels. Be-

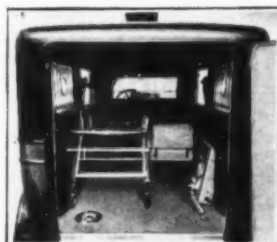
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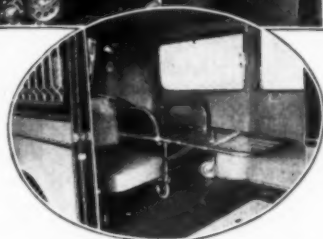
There are many unusual safety factors in the design of this Studebaker ambulance. It is not a passenger car chassis lengthened, and therefore weakened, by splicing. The deep steel frame is braced by 7 stout cross-members; the wheelbase is 158 inches; rear axle and propeller shaft are extra large; long, resilient springs and full-size balloon tires; 4-wheel hydraulic brakes. The motor is the powerful Big Six engine—smooth, quiet and notably free from vibration.



Equipment includes Bomgardner folding chair cot and two removable, upholstered folding chairs.

In addition to the wide rear opening, 32-inch doors are provided on each side.

Roominess is matched by completeness. Note the flower vases, heater, fan, lights and window shades.



The interior is roomy and luxuriously furnished. Broad doors permit the Bomgardner cot to be loaded from either side or from the rear. Unusually complete ventilation system with adjustable door windows, roof-ventilator, electric fan and movable glass panels at front admitting air from the three cowl ventilators. Patient's compartment upholstered in gray leather or mohair. Two folding seats for attendants; room for two additional passengers with driver.

Equipment includes an inside-controlled spotlight; metal name-plates for front and side windows; full-vision windshield with sun-proof visor and automatic cleaner; motometer; front bumper; extra balloon tire, tube and cover. Speedometer, 8-day clock, gasoline gauge, hydraulic brake pressure gauge, ammeter and oil pressure gauge are mounted in an oval group under glass.

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sides the fish, vegetables are added, such as onions, garlic, tomatoes, carrot, chillies, leeks, or shallots, a bouquet garmi (Parsley, celery, saffron, bay leaf, thyme) and cloves. It is very highly seasoned.

Bisque and cray fish soup are synonymous terms in France. This is an ancient soup first made by the chaplain of Francis I, who was king of France in the first half of the sixteenth century. The cray fish are first boiled (from 40-100 are mentioned in different recipes). The meat from the tails is used in the soups. The bodies, tail sheaths and claws are pounded with anchovies, then cooked in fish broth. This is strained, poured over the fish tails and garnished with fish forcemeat queuelles.

Haricot is the French name given to a thick meat stew. Haricot in old French means a morsel. Haricot of mutton is a ragout of hashed mutton and turnips, while a haricot of bean is a combination stew of meat and the dried bean.

After the French Revolution, the conditions of the poor improved, and the use of the pot au feu was revived. The national taste of the people changed, instead of the highly spiced food, they preferred a bland simple diet.

As we leave France to enter England, we cross Netherlands or Belgium and as we pass through the country we will take notice of the soups served on the journey.

The waterzoei is made from several kinds of fish similar to the French bouille-a-baisse. The kinds of fish may differ; carp, eels, tench, roach, perch and barbel were some of the kinds used in Belgium.

Potage Leman has for its foundation a meat gravy. Two purees are made separately with the gravy, then the two are blended. One is made by adding peas to the gravy; from the other part a tomato puree is made. A teaspoon of wine is allowed for each person. This soup was named for the defender of Namur. As one might expect, we found a puree of Brussels sprouts near the city bearing the name. At Ghent there was a hoche pot made of fresh pork and cabbage. Other vegetables lend variety to it; sometimes a trotter was used. At Ostend the oysters were served in a white fish soup, made from the trimmings of fish; cream was added before serving.

Historical Soups of England

From Ostend we crossed to England. In 1290, soup is mentioned in the history of England by the Bishop of Herford, and in the fifteenth century at the marriage of Catherine of Valois to Henry V of England, the Archbishop of Sen headed a procession of priests who bore the soup and wine to the royal chamber.

At one time (whether or not the custom continues I could not verify) the Prince of Wales ate a bowl of Crécy soup on August 26. The custom was to commemorate the Battle of Crécy and the valor of the Black Prince. This is the carrot soup previously mentioned. Only the orange coat of the carrot is used in the preparation.

Another custom, which has prevailed in Great Britain since the reign of King George IV, is for the names of the cooks or chefs, who have prepared the dish, to accompany it to the table as it is served to the king. It happened, so the story is told, that at the death of the court chef, the king had chosen to fill his place an assistant who had made a Rhenish soup to his majesty's taste. Quite naturally, the choice caused jealousies among his fellow cooks. They sought to gain prestige for themselves by defaming the king's new appointee, so when any dish, which was served, displeased the king, they would say it was the man of his choice who made it. The king became suspicious of a plot in his culinary department and established the custom which we have mentioned.

They used to say in England that soup was synonymous with turtle, and when it was served at Painter's it prepared the way for a lark's pudding. This may have been at a sportsman's dinner. London was famous for her soup houses. In a recent *New York Times* we saw that Birches, a soup house which had been in existence since 1690, was to be torn down. Turtle soup had been made every day in this house for 230 years. Turtle soup is called the emblem of the Lord Mayor. The method of preparing the soup is kept a secret. The firm, we understand, continues in a more modern club house. The iron pot is as typical in England for the preparation of soups as the bain-marie or the pot au feu is in France. The cereal soups or gruels in London were called "skilly" because they were cooked in a skillet.

The beef steak pudding of Sussex is the famous stew of England. Round steak is cut in pieces with two kidneys, mushrooms and oysters. It is cooked between two crusts. Mary Lamb served this at an evening's entertainment. Cheshire Cheese was famous for its beef steak and Lark's Pudding. Civit of Hare is strictly an English dish that is not served on the continent. The hare is cut in pieces and browned in butter; onions, chopped ham, vinegar and herbs are added.

Fourteenth Century Scotch Soup

Stepping across the border into Scotland, we are told that the cock-a-leekie soup recipe is the oldest on record. It dates back to the fourteenth century and is made of chicken and leeks, with carrots and celery added as flavor. The Ettrich Sheppard said that the "man was an atheist who first polluted it with prunes." "Prunes give it a sickening sweetness that made it taste like a mouthful of cockney poems."

The Scotch broth is delicious, prepared from a neck of mutton cooked with onions and cloves; prepared vegetables and barley cooked separately are added before serving. The Scotch crowdie is a soup of the Scotch oatmeal cooked in mutton broth for three hours, with chopped onion and parsley. It is served with toast.

The hotch potch of Scotland, or hodge pot, is a jumble of all kinds of ingredients: mutton or lamb cut in small pieces, served with peas, carrots, turnips and celery.

We did not actually reach Ireland, but as we took a homeward boat we thought of the Savory Irish stew so typical of that isle.

Having taken a bird's-eye-view of the idiosyncrasies of our neighboring countries on the other side of the globe, let us stop a moment longer to discuss our own soups. The soups originating in the United States are the corn soups and the chowders.

Fresh corn is cut from the cob and combined with milk in a cream soup, or it is used in the South with a soup plus, which is made from many vegetables. The dry corn is ground coarsely and prepared in gruels and porridges. It figured very largely in the diet of our early ancestors. Corn contains a larger amount of fat than some of the other cereals, therefore is more valuable in the diet.

The following recipe was taken from Williams' recipe book of the "Old South." It was the size of the recipe which attracted our attention.

"Take two gallons of water. Then use chickens partly grown and one-half pound of bacon. Chop ham and onions, brown in the bacon fat, add the water and cook chicken one hour with two pods of red pepper, pepper-corn and parsley; then add two small heads of cabbage shredded, six white potatoes sliced one-quarter of an inch thick. After these have cooked fifteen minutes, add one quart of string beans, cut, one pint of lima beans, celery, a pint of okra sliced, one dozen tomatoes peeled and sliced, one dozen ears of corn, split the kernels lengthwise and scrape out the pulp. Thicken the soup with butter and flour balls. Serve with hoe cake, corn and cider."

By-products

IN addition to raising a required fund, a campaign advertises the hospital in the most thorough and effective way possible. Hundreds of campaign workers and thousands of contributors become valuable new friends. Improvement is sometimes noted in collection of regular hospital accounts. Subsequent small maintenance appeals generally prove more, instead of less, productive than before. Many bequests are silently arranged. These by-products are sometimes regarded as of equal value to the actual money raised.

We shape our methods so as not only to raise money but also to make permanent friends for the hospital.



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The chowders, as we mentioned, originated in the United States. The name came from "chaudiere," the big pot in which, we are told, a party of shipwrecked emigrés cooked the fish they caught with bacon and potatoes from the ship's stores. Pilot crackers were served in it. The chowder varies with the locality where it is made. We find Boston famous for its fish chowder. One part of Rhode Island serves its clam chowder red with tomatoes, but Narraganset prefers it with milk. Connecticut also uses milk or cream. As our steamer stopped at various ports along the Atlantic we found the Maryland clam chowder and the Alabama fish chowder each adapted to please the people of the locality.

As we travel to the west we are served chicken gumbo in New Orleans, Mississippi and Kentucky. This soup was probably handed down from the early Spanish settlers. Ohio has its particular brand of chicken soup; so also has Vermont. Washington is noted for the famous White House consommé which is served at its diplomatic dinners.

As we have shown, soup originated as a one-piece dinner, but today we have come to adopt it as a prelude to the dinner. It must be at its best, for on its perfection depends the impression of the whole dinner. The nutritionists impress upon us its value in the diet not so much for its nourishment as for the refreshment it furnishes the weary traveler and for the stimulation of the gastric juices.

BUYING GLASSWARE*

The purchasing of glassware is a far simpler matter than the purchasing of china, there being much less detail in the matter of design, sizes and shapes. After the purchase of china has been made, only a few articles of glass are needed to complete the equipment for a hospital.

The main requirement is to become familiar with the quality of glass and to know the most practical items for the particular service, such as tumblers, sherbet glasses, sugars and creamers, oil and vinegar bottles, egg cups and pitchers.

Table glassware of all kinds is either *blown* or *pressed*. For the present we will keep in mind, especially, the drinking glass or tumbler, the most important of the items to be purchased.

Blown glassware is made in two grades, *lead blown* and *lime blown*—the lead being stronger, clearer and with a ring by which it can easily be distinguished from the lime.

The basis of all glass is white sand, the purest that can be found; and one of the purest sands in the world is found in Berkshire County, Mass. The sand is mixed with various materials according to the knowledge and science of the manufacturer.

The principal materials in lead blown glass other than sand, are red lead, bicarbonate of soda and potash, which chemicals give it strength and clearness.

Lime glass contains lime instead of lead and no potash. It is not quite as clear crystal as the lead blown, and has not the ring to it.

In large establishments where there is a great rush of business most of the buyers believe the lead blown glass, although more expensive, to be the more practical, as its use in the long run results in less breakage. In small places, however, where care is used in handling and washing, the lime blown glass is found to be satisfactory.

It should be understood, however, that there are various grades in both the lead and the lime, that quality governs

the cost, and that reliable dealers make their prices on the basis of quality.

The cheapest glassware is not profitable at any price. The idea we sometimes hear expressed that the cheapest is just as good because it will break anyway is wrong. Glassware must contain the proper materials to give it strength.

Pressed glass is also made in two grades, called *pot* glass and *tank* glass. These tumblers are, of course, thicker and heavier than the blown.

You can easily detect the difference in quality between the pot glass and the tank glass, as the pot glass is much clearer, better finished and more highly polished.

As far as breakage is concerned, most of the mortality in pressed glass is caused by sudden changes from cold to heat. Pressed glass should not be plunged into scalding water after being used for ice water.

In such articles as sugars and creamers, oil bottles, sherbet glasses and egg cups there is nothing better for tray service than the pressed colonial glass. With this colonial glass optic blown tumblers may be used inasmuch as almost everyone prefers drinking from a thin glass.

For practical purposes the straight edge tumblers are preferable to the flaring shape. In handling and washing the flaring edge tumblers the edges are more easily chipped or broken by contact than are the straight edges.

The difference between poor and good glass is easily detected, if samples of the different grades are studied.

To review the situation, the most important points to remember when selecting glassware are:

1. That there are two kinds of glass—blown and pressed.
2. That quality governs the price.
3. That there are two grades of *blown* glass—lead blown and lime blown; the lead blown being of better quality than the lime blown, therefore costing more.

THE DIETARY DEPARTMENT TODAY

The hospital superintendent knows that the dietary department of today is much too important a matter to be dabbled into by a mixture of departments. The dietitian can no longer serve type diets—the identical articles of meat, potatoes, vegetables, pudding and beverages to each patient—as in the days when the head nurse had charge of food distribution. The patient is an individual and although it may be due to his own fault that he is sick and in the hospital it is our business to help him back onto his feet. The dietitian realizes that the hospital exists for the patient. Incidentally it is a training school for nurses, interns and dietitians but first and foremost of all it is established or endowed by the commonwealth or the community for the purpose of rehabilitation and that process is an individual matter.

So we have seen very briefly the changing character of our large hospitals from places where responsibility was divided, where there was much friction, and where the main thought was to go through the day's work and keep the place clean, to a place where "unit responsibility" is the foundation, the departments are in charge of alert, happy people, all given a chance to do a piece of creative work and every one is working for the best comfort of the people for whom the hospitals are really organized—the patients.—*Dietary Administration and Therapy.*

Benedictine Hospital, Kingston, N. Y., has secured the services of Lucy V. Scott, who has been at the City Hospital, Boston, Mass.

*Extracts from a paper read before Massachusetts Dietetic Association by J. E. Norcross, Boston.

"Just What a Ligature Should Be"

Fresh Material: Armour's Sterilized Surgical Catgut Ligatures, Plain, Chromic, and Iodized, are made from sheep gut collected in our own abattoirs, where all animals are subject to State and Federal inspections before and after slaughtering.

Fresh material is selected, washed and rinsed in running water until it is mechanically clean. The gut is then split lengthwise and the mesenteric portion is discarded. Nothing but the smooth side is used. This insures a string that is free from weak spots and knots and that is absorbed uniformly after being imbedded in the tissues. The strands are then slimed, scraped and treated in such manner as to remove all but the clean sub-mucous lining. During this process, requiring several days, the material is kept at a low temperature (near freezing) to prevent fermentation and minimize bacterial growth.

Sterilization: While in a moist state and immediately before spinning and drying, the strips of gut are sterilized in an air-tight chamber by means of sulphur fumes.

Hand Polished: After drying, all Ligatures are hand polished until perfectly smooth. They are then taken off the racks and gauged, sorted, and all traces of fat removed by proper solvents.

Chromicizing: Chromicizing of Ligatures is done in a way to make the strings stand up in the tissues 10, 20 or 30 days, as may be desired.

The Plain and Chromic Ligatures are cut into proper lengths, placed in sterile tubes, and completely freed from moisture by heat and covered with storing fluid. The Tubes are here sealed and sterilized at 320 degrees F.

Special Sterilization: A special sterilizer built of brick, steel and tile was designed by the Armour Construction Dept. Superheated steam, generated in a small chamber, is regulated by self registering mercury thermometers with charts, which are kept for reference.

After the final sterilization samples are taken from each batch and tested in the Bacteriological Laboratory by bacteriologists who are entirely independent of the manufacturing work.

The Armour Sterile Catgut Ligatures are supplied as follows:

Plain and Chromic, Regular (60 inch) lengths, sizes 000, 00, 0, 1, 2, 3 and 4. Boilable or non-boilable.

Plain and Chromic, Emergency (20 inch) lengths, sizes 000, 00, 0, 1, 2, 3 and 4.

Iodized, Regular (60 inch) length, sizes 00, 0, 1, 2, 3 and 4.

An Armour Staff is working patiently and constantly in scientific research and in the commercial production of those surgical and pharmaceutical materials, whose only legitimate origin is the successfully conducted abattoir.

PHARMACEUTICAL DEPARTMENT

ARMOUR AND COMPANY
CHICAGO



For complete index of advertisements refer to the Classified Directory

HOSPITAL EQUIPMENT AND OPERATION

With Special Reference to Laundry, Kitchen and
Housekeeping Problems

Conducted by C. W. MUNGER, M.D., Director,
Grasslands Hospital, Valhalla, N. Y.

GETTING THE MAXIMUM USAGE FROM HYPODERMIC SYRINGES AND NEEDLES

SOME hospitals undoubtedly lose money and jeopardize the efficiency of their nurses and doctors through lack of care in selection of their hypodermic syringes and needles and through improper maintenance of these articles after they have been purchased. Those who are familiar with the details of the surgeon's work in the operating room and the duties of the nurses on the wards, fully realize the inconveniences and difficulties arising from lack of care on the part of the buyer of hypodermic supplies.

What surgeon has not found at the last minute that the needles for use in administering a local anesthetic are of the "record syringe" type, while the barrel that has been furnished is of the Luer type, taking a different size of needle. Such delays are common and often costly. We have probably all stood at the bedside of a patient in shock or some other condition requiring immediate medication, only to find that the nurse in her haste has prepared a needle that does not fit the syringe or does not fit snugly, the result being that the medication is either delayed or half of the solution escapes about the nozzle of the syringe. One often wonders when noting on a nurse's record that a patient received one-fourth of a grain of morphine or one grain of caffeine, as to whether the patient did receive all of this medication or only a part of it. Most of these difficulties will be overcome if the hospitals will standardize the sizes of hypodermic syringes and needles. A type of syringe that stands boiling with the minimum of breakage, that has a plunger carefully ground to fit and to stay fitted to the barrel should be selected.

Buying Both from Same Manufacturer

Having obtained a desirable type of syringe, it should then be ascertained what particular type or make of needle will consistently fit this syringe and deliver the medication into the patient's system. It is usually wise to use syringes and needles from the same manufacturer; only careful testing, however, over a period of time will prove this to be true in any given case. The following are some suggestions as to sizes of syringes that are generally used for various purposes:

- Aspirating: capacity 20 cc.
- Bacterial vaccines: capacity 1 cc. or 2 cc.
- Blood transfusion: Lindeman method, capacity 20 cc.;
Abelman & Strauss methods, capacity 100 cc.
- Insulin: specially engraved syringes, 1 cc., 1½ cc., 2 cc.,
to give units 10-20-40.
- Intravenous: (neo-arsphenamine), 5 cc., 10 cc., 20 cc.
- Intravenous: (arsphenamine or salvarsan), 50 cc., 100 cc.

For intravenous work a syringe with eccentric tip is more convenient, in that it allows insertion of the needle parallel to the surface.

Local anesthesia: capacity 5 cc., 10 cc.

These syringes should have the special locking spring to keep the barrel from slipping.

Tonsil and oral surgery: capacity 3 cc., 5 cc.

These syringes should have special locking feature.

Subcutaneous and intradermal: capacity 1 cc., 1½ cc., 2 cc.

Tuberculin and intradermal: syringes specially graduated in 1/10 cc.: capacity ½ cc., 1 cc.

Wasserman test: capacity 10 cc.

The life of glass syringes may be greatly prolonged if, after use, they are washed with warm water and cleaned with alcohol and ether. This will prevent the barrels from sticking. They may be sterilized by dry heat or boiling. For best results, separate barrel and plunger and, if sterilized by boiling, good syringes that have been heat treated to prevent breakage caused by sudden changes of temperature, may be put directly into hot water to hasten the sterilization. Care must be taken not to sterilize in distilled water or in any solution containing sodium bicarbonate, as both will cause disintegration of the glass.

To remove stains, soak in concentrated nitric acid, wash with warm water and then with alcohol.

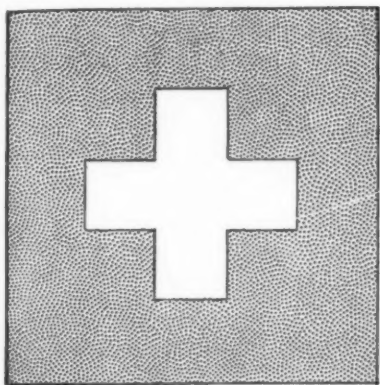
The manufacture of good needles is a process of precision, and the satisfactory needles are obtained from manufacturers where every operation is followed by careful inspection, so that needles are as free from defects as is humanly possible.

Manufacturers provide especially designed needles for the following purposes:

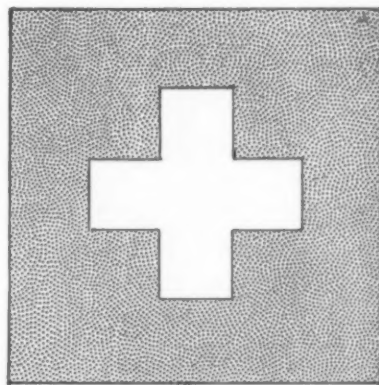
- Intradermal work and Schick test.
- Regular hypodermic needles.
- Camphorated oil and serum.
- Intravenous work.
- Intramuscular work.
- Aspirating.
- Infusion.
- Transfusion: recipient needles; donor needles.
- Spinal work.
- Tonsil work.
- Wasserman test.
- Abscess work.
- Lachrymal work.

The equipment for regional and local anesthesia should contain an assortment of needles for the following purposes:

- For raising the wheal.
- For injection in the wrist, scalp, finger, toe.



Every Hospital can now enjoy the convenience of Gas Service



IF YOU do not have city gas service, you will find Pyrofax a real convenience in the main kitchen, the diet kitchens and the laboratory.

Pyrofax is made from natural gas and is shipped to the consumer in steel cylinders. It is non-toxic and burns with a clean, hot flame free from soot or odor. It can be used on any standard gas appliance — ranges, hot plates, Bunsen burners, and laundry ironers.

The Pyrofax installation consists of a substantial enameled steel cabinet which houses the cylinders and fittings. It is placed on the outside of the building and the gas is piped from it through ordinary gas pipe to the stoves, burners and other appliances. It is listed as standard by the National Board of Fire Underwriters.

Any further details will be promptly furnished on request. May we not send you our circular and booklet describing Pyrofax?

CARBIDE AND CARBON CHEMICALS CORPORATION

General Offices

Carbide and Carbon Building
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Pyrofax

TRADE MARK

REAL ESTATE LOANS

TO THE BORROWER:

Statistics covering building construction throughout the United States in the last few years show conclusively that **CHURCHES, SCHOOLS, CONVENTS, HOSPITALS**, and all classes of buildings intended for religious purposes, continue to keep abreast of the times in the erection of new buildings.

Recognizing a sound, economic law, those in charge of religious houses are financing the construction of these buildings or refunding existing indebtedness by a first mortgage loan extending over a period of years. In this manner the benefits and responsibilities are shared by the present and future generation and the burden is not found irksome by either.

For more than twenty-six years the Mercantile Trust Company of St. Louis, Missouri, has made a specialty of financing churches and religious institutions, not only in its home city but in practically every section of the United States. Millions of dollars furnished by it have made possible the erection of scores of institutional buildings throughout the land. Through these years of experience in handling loans of this character we are in a position to give valuable advice and assistance in such transactions.

Correspondence and interviews invited.

TO THE INVESTOR:

Operating on a very extensive scale, with a broad field from which to select our loans, we are enabled to offer at all times, to investors, not only the maximum of service but a class of securities that measure up to the highest standard of safety and desirability.

Complete detail circulars of issues we now offer mailed on request. Purchases of notes made by non-residents filled with the same dispatch as locally. Delivery made at our own risk. Reservations may be made for immediate delivery or delivery within thirty days.

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EIGHTH AND LOCUST

Capital and Surplus Ten Million Dollars
-TO ST. CHARLES
SAINT LOUIS

Capital and Surplus Ten Million Dollars

For paravertebral (cervical block, dorsal block, lumbar block).

For sacral anesthesia.

For spinal anesthesia.

Abdominal field block.

Splanchnic anesthesia.

A great many special needles for intravenous, blood transfusion, spinal work, and Wasserman tests have been devised. Recently, however, the ordinary straight needle with a medium length but a sharp point is given preference in intravenous and blood transfusion work.

The New York Board of Health uses a nineteen gauge needle for the Wasserman test. For blood transfusion work, suitable needles for the donor are fourteen or fifteen inch, and a seventeen inch needle is used for the recipient.

All needles should be made of non-rusting materials or from seamless, high carbon steel. Needles made of high carbon steel and properly tempered will take a keener cutting edge than any other metal. They also possess greater strength and stand up better in use.

Platinum-iridium needles are quite hard, hold their points well, and will not corrode or lose temper in the flame, provided they are not heated beyond a dull red color. They have the advantage of being unaffected by chemicals, they may be resharpened as often as is necessary, and if used with care will give good service.

Gold and nickeloid needles are rustless and non-corrosive for most uses; they must, however, be sterilized by boiling, as they will not stand the flame, the metal being slightly softer than steel or platinum-iridium and the points are thus more easily dulled.

Steel needles after use should be rinsed in alcohol or ether and then dried either with compressed air or by the use of patent needle drier. A wire dipped in oil or vaseline should then be inserted. Needles treated in this manner will last longer and will not rust. When sterilizing platinum-iridium needles in flame, they may be heated to a dull red, which is sufficient to kill bacteria. Long continued excessive heat renders the needles brittle. Lateral pressure, such as bending back and forth, while inserting the needle, is undesirable, as it soon weakens the walls of the needle and causes it to break or leak.

Frequent honing of steel, platinum-iridium, gold, and nickeloid needles on an oilstone will keep the points smooth and increase their satisfactory usefulness.

By careful testing, select the syringes and needles that are most satisfactory to the hospital and its doctors and nurses. Adhere to this standard and do not buy small job lots of needles or syringes that may not fit the equipment already in stock, and that may be of cheap manufacture. Having secured a good standard equipment, take every precaution to see that this equipment is intelligently and properly used and that every needle and every syringe has the painstaking care that will prolong its life and usefulness.

A GLASS TUMBLER OF UNUSUAL DESIGN

By C. W. Munger, M.D., Director, Grasslands Hospital, Valhalla, N. Y.

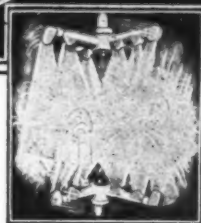
Chipping and breakage of institutional glassware is a perennial problem. An attempt to minimize this difficulty has been made in the design of the glass tumbler shown.

A patented principle, consisting of a groove about the neck of the glass, is the special feature of this tumbler. The indentation reinforces the wall of the tumbler and takes up the force of shocks that would shatter most ordinary ones. The groove is designed also as a sure finger-

In CRESCENT RACKS 30 dishes are washed as one without clatter or breakage

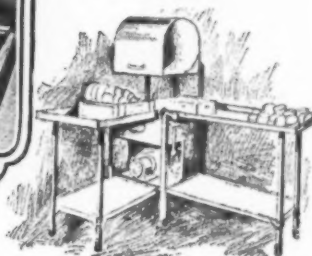


Only Crescent has the double REVOLVING wash



The safest, most EFFICIENT wash-action known

COMPACT MODEL "K", ideal for the diet-kitchen, fits anywhere, even in a corner.



Surer Sanitation of Dishes

Lighter, Faster Work and Less Expense

WHEN YOU INSPECT your washed dishes and check up your dishwashing costs, consider the great improvements now to be had.

SANITARY CLEANLINESS at all times, even when the work is done by the least experienced help;—greater savings in wages, dishes and upkeep;—such improvements are well worth investigation.

This information belongs in your files

THE EXPERIENCE IN MANY WELL-KNOWN hospitals is that these remarkably efficient Crescent machines *actually pay for themselves* in a short time by savings in dishes and wages alone,—not considering the advantages of the simpler, safer method, greater speed and lighter work. We can send you convincing letters written by

Superintendents who have had this experience, in hospitals well known to you. INSTALLED NOW, to replace sinks, old machines or obsolete methods—one or more of the New Crescents will save space in any kitchen, large or small, and will provide just the right capacity for any number of dishes you have to wash, either a great many or a few at a time.

Ask for Booklet on the New Crescents

THE SEVEN NEW CRESCENTS are specially suited to hospital needs—in ward-kitchens or main pantry.

MONEL, COPPER, OR GALV. IRON construction in all models, at prices you can afford. A post-card mailed today will bring complete information from Crescent Washing Machine Company, New Rochelle, N. Y.

CRESCENT DISHWASHERS & GLASSWASHERS

This Month

Rubber Sheeting

DOES your institution carry mattress insurance? If not it is because you are not using Universal "Invincible" Double Coated Maroon Heavy Duty Rubber Hospital-Sheeting. Guaranteed for five long years of hospital service! It will not wrinkle, crack or peel and affords a maximum of comfort to restless, bed-tired patients.

COSTS MORE AND WORTH IT

Universal "Invincible" sheeting is soft, live and resilient. Its superiority is uncontested. It wears five times as long as ordinary rubber sheeting and delivers many times the wear and satisfaction. That makes the "INVINCIBLE" the most economical rubber sheeting you can buy at any price.

36", 45", 54" widths, \$2.00 per sq. yd.
5% Discount on orders 50 yds. or over.

UNIVERSAL "INVINCIBLE" SERVICE AND DEPENDABILITY

Universal "Invincible" hospital sheeting is made under our own secret process. Only the very highest quality of materials obtainable are used. Genuine Sea Island cotton fabric base is impregnated with pure India Rubber.

Our name is moulded on the selvage of each yard. It is our guarantee and your protection. Ask for prices today.

Write for Complete Catalog of guaranteed Hospital Supplies and Equipment.

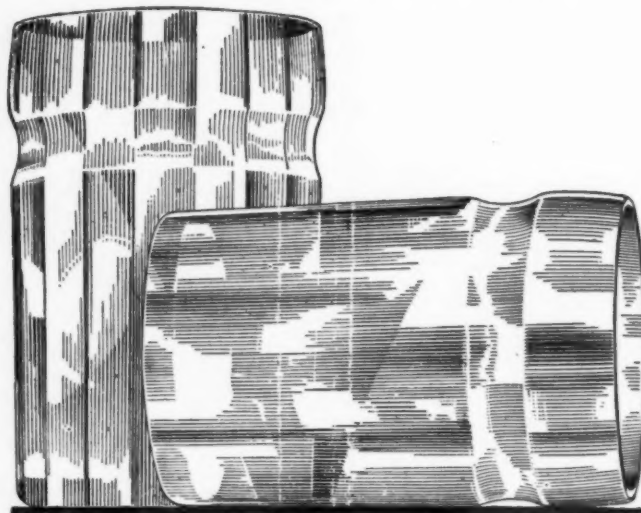
**Next Month—
Rubber Gloves**

**Universal
Hospital Supply Co.**

500-510 N. Dearborn St., Chicago, Ill.

hold, lessening the probability of the wet glass slipping out of the grasp. The lip of the tumbler is cupped inward very slightly, but enough to prevent the lip from striking when the tumbler falls on the side, or when several are bumped together.

This tumbler is so designed as not to permit nesting,



which feature is a necessity for breakage prevention in institutions. It is made in all standard sizes and of good quality, extra heavy glass, plain or optic style. The appearance is unusually good, particularly in the optic glass, the proportions and clearness being extraordinary. It is heavy enough to be serviceable, yet not so thick as to be clumsy.

The manufacturers' claim that this glass will last twice as long as the usual type, may be extravagant, but a short period of testing on the part of the writer has seemed to prove the manufacturers' claim worth investigating.

A BANDAGE-CUTTING MACHINE THAT IS EASILY OPERATED

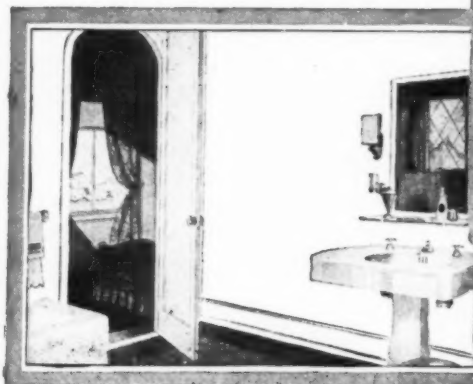
Difficulty is often experienced in making smooth, tightly rolled muslin bandages and executives will be interested in the bandage-cutting machine here described, which was designed for use in the Jefferson Hospital, Philadelphia.

The machine is easily operated and can be adjusted to cut any width of bandage. Its successful operation depends mainly on the care exercised in preparing the material to be cut. The actual cutting is a simple operation.

A half-inch horse power motor is required to operate the machine. The cutting knives are standard razor blades and can be adjusted to cut any width of bandage. Less than one quarter of each blade is used at one time, and as the oscillating movement makes a shearing cut these blades should cut many yards of bandages before they become dull. When they show a tendency to drag, loosen the holding screw one or two turns and swing the blade. Remove the blade and reverse it and repeat as above, which will give four cutting edges. The blade can be honed in the regular handle.

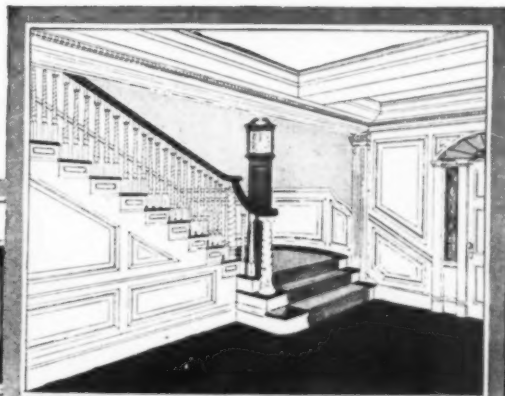
Open the bolt of 36-inch cloth out flat, and place it in the box at the bottom. Divide it as nearly as possible so that a portion will fall over each side of the box. Pass the end between two of the tension bars underneath the table and down to the square mandrel near the bottom of the machine. Fasten it with thumb tacks, one at each mark, two inches apart; do not stretch in width. Put the two outside tacks in first, starting at the outside

This famous paint is now made three times as useful to you , ,



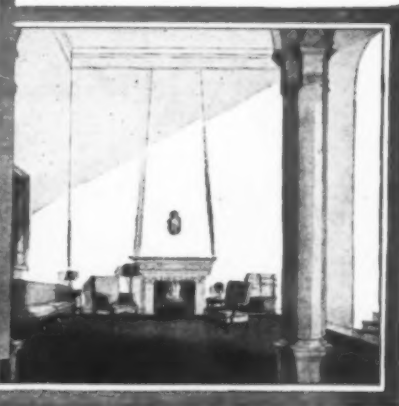
Barreled Sunlight Gloss

For bathrooms, lavatories, kitchens, corridors—wherever maximum light and cleanliness are essential—the washable finish of Barreled Sunlight Gloss is the established favorite.



Barreled Sunlight Semi-Gloss

For stairways, hallways, etc., where conditions require less than a full gloss finish, Barreled Sunlight Semi-Gloss gives adequate light and long-lasting good looks. As easily washed as the Gloss, but has a still softer lustre.



Barreled Sunlight Flat

For well-lighted rooms, lounges, lobbies—where duller effects are sometimes desired—nothing is more suitable than Barreled Sunlight Flat. Handsome and washable—though naturally less durable than Gloss or Semi-Gloss.

In Gloss, Semi-Gloss and Flat finishes , , for any interior painting job , , white or easily tinted

SMOOTH, deeply lustrous, handsome as fine enamel—easy to keep clean and hard to wear off! For these qualities Barreled Sunlight has long been *the most popular white gloss finish.*

And now its practical value to you has been *trebled.* You can get this superior paint not only in the Gloss finish but in Semi-Gloss and Flat as well. Moreover, Barreled Sunlight can easily be tinted—which makes it available for *every interior painting job.*

In all three finishes, Barreled Sunlight has remarkable "covering power." And it is easy to apply—flowing on readily with brush or spray.

When used in the white, Barreled Sunlight resists for years the yellow-

ing tendency of ordinary white paints and enamels—an advantage due to the exclusive Rice Process of manufacture.

Sold in 55- and 30-gallon churn-equipped steel drums, and in cans from 1-2 pint to 5 gallons. Where more than one coat is required, always use Barreled Sunlight Undercoat first.

Use the coupon to obtain illustrated booklet and sample panel painted with Barreled Sunlight.

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Factory and Main Offices
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Retailed by over 6000 dealers

By simply mixing colors in oil with Barreled Sunlight white, the painter on the job can easily obtain any desired shade. In quantities of 5 gallons or over we tint to order at the factory, without extra charge. For tinting small quantities our dealers carry handy tubes of Barreled Sunlight Tinting Colors. They are almost liquid, blending easily and quickly with Barreled Sunlight.



Barreled Sunlight

Reg. U. S. Pat. Off.

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Please send me your booklet "Interiors of Lasting Whiteness," and a panel painted with Barreled Sunlight. I am interested in the finish checked here—
Gloss () Semi-Gloss () Flat ()

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City..... State.....



St. Luke's Hospital,
So. Dartmouth, Mass.
Bldgs.:
Stone & Webster.



Soundproof and Fire Safe Floors

You can build up to the highest standards yet build with marked economy by using Truscon Steel Joists for floor construction. These joists provide the necessary fire safety, rigidity, and soundproofness for patient safety. Yet because of swift erection, minimum field labor and simplicity of installation, Truscon Steel Joists lower your costs. You get a better, more economical construction when you use Truscon Steel Joists.

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TRUSCON STEEL COMPANY,
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Stocked by Dealers Everywhere

TRUSCON

STEEL JOISTS

marks. Give the mandrel two turns to get the material securely anchored. See that it winds on straight at the edges. When all the material is wound on except enough to reach the top of the machine, lock the handle to prevent unwinding.

Remove the shaft that carries the knives and drop the spreader bar at the back of the machine by removing the taper pins at each side. Place the square rod on the top graduated bar of the machine, entering the two dowel pins in the holes provided for that purpose. Pass the end of the material between the tension bars, following the arrows as before, then through the slot in the table, on up to the square rod at the top, to which it is attached in the same manner as was followed in fastening to the lower mandrel, except that it is pulled to an even tension as it is fastened to the square bar, without regard to the



unevenness of the end. When all tacks are in position, cut off the surplus material even with the rod.

Replace the knife bar with the blades in a vertical position. This will necessitate the removal of the square cam shaft, which is held in position by a tension spring. When the knife bar is in position and the wedge caps are properly fastened, throw the knives forward and cut through the material, replace the cam shaft and spiral tension spring on the knife bar, unlock the handle and reset spreader bar. Raise the square rod until it clears the dowel pins, allow it to rest on the graduated bar and rotate it until you have eight inches of material wound, measuring from the top of the graduated bar. Unwind and remove the thumb tacks; finish each cut to the end as straight as possible with a pair of sharp shears.

Begin at the end with the first strip, pass it over the graduated bar keeping in alignment with the graduations, pull snug and hold with the fingers with the device provided for that purpose. Continue the material around the rod and tuck it under that portion held by the fingers. Repeat until all the strips are on, rotate the rod two or three turns to properly anchor the bandages, then set the tension rods the same as before. Start the machine and continue until the bandage is of the desired diameter, then fasten each with a pin, wind on enough more material to measure eight inches from the pin to the edge of the graduated bar, then reverse the motion until the pins are in convenient position to cut the bandage loose. Draw out the square mandrel and the finished bandages will fall off.



Reason No. 1 for Standardizing on Pequot

FIBRE

PEUQUOT durability begins out in the cotton fields. The length and strength of cotton fibre depends on many variable factors—the weather, for instance. The highest grade cotton does not come from the same locality year after year.

Pequot tests hundreds of samples of cotton each season—accepts the *long* and *strong* staple only.

A supply of staple up to the Pequot standard is always kept in reserve so that

Pequot sheets at all times will be made from *only* the best fibre obtainable.

That's one of the reasons why Pequot has built up an extraordinary reputation for durability, finish, service.

You can safely standardize on Pequot. Their quality will remain fixed—the best.

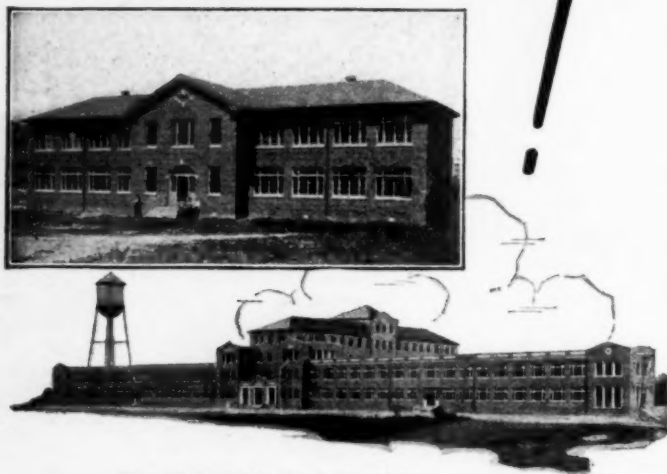
Made by the Naumkeag Steam Cotton Company, Salem, Mass. Parker-Wilder & Co., New York and Boston, Selling Agents.

STANDARDIZE ON



CHAMBERLIN

Choice for / America's Leading HOSPITALS



U. S. Veterans Hospital, Aspinwall, Pa.
W. F. Trimble & Sons, Gen. Contrs. Seven
buildings completely equipped with Cham-
berlin—24,000 feet of metal weather strip.

THE PREFERENCE for Chamberlin equipment by America's leading hospitals is founded both on logic and experience. For 33 years, Chamberlin, the original metal weather strip, has remained the accepted standard. For 33 years, Chamberlin has constantly pioneered new developments in the art and has made the name Chamberlin synonymous with the best—the most advanced—in metal weather strip equipment. Whenever builders want the finest in weatherstripping, there you will find Chamberlin. Chamberlin equipment is preferred because experience has demonstrated that there is ample reason for such preference. Chamberlin manufactures every inch of its equipment, installs it and assumes full responsibility for correct installation—and guarantees and services its installations for the life of the building.

Write for Chamberlin Literature

CHAMBERLIN METAL WEATHER STRIP CO.

West Lafayette Blvd., Detroit, Mich.

100 Sales and Service Branches Throughout the United States



Chamberlin Metal Weather Strip Co.
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Please send me literature on Chamberlin Metal
Weather Strips and Inside Door Bottoms.

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A PORTABLE SOAP DISPENSER THAT IS OPERATED BY A FOOT PEDAL

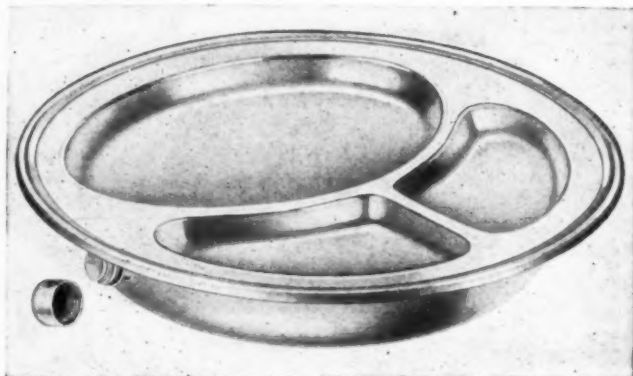
A portable soap dispenser for use in the surgeons' and nurses' scrub-up room, operating room, delivery room and wherever such an instrument is necessary to complete aseptic scrubbing has recently been placed on the market. The dispenser is operated by a foot pedal, which makes its use non-contact, and leakage is eliminated by a positive force feed pump. It is thirty-six inches high with a thirteen inch base that forestalls tipping.

The dispenser has a swivel setting and may be moved to any part of the sink, a dispensing tube of sixteen inches facilitating ease of operation. This tube may be removed for sterilization purposes.

AN IMPROVED FOOD CONTAINER

A means of keeping foods at the temperature at which they are placed in the containers is offered in a recent product, a three compartment plate, with a hot water chamber.

The plate is constructed of 21 per cent nickel silver hollow ware, is eleven inches in diameter, and achieves the acme of quality and practicability. The hot water cham-



ber, which is filled at the water faucet before the foods are placed on the plate, guarantees hot food being served to the patient although the meal may be unavoidably delayed in transit.

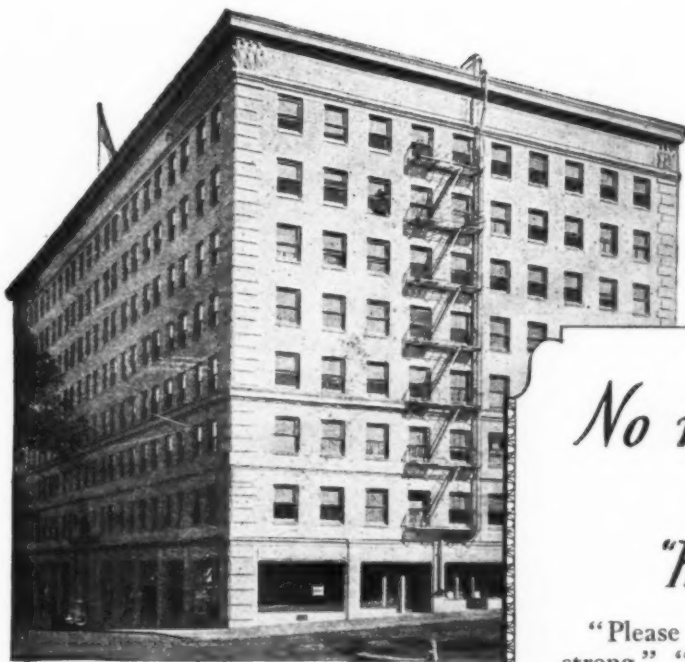
The accompanying illustration shows the three compartments for food, and also the spout for filling the hot water chamber. The cap screws on tightly and allows no water to leak from the chamber.

SEMI-HEAVY DUTY PORTABLE VACUUM CLEANER

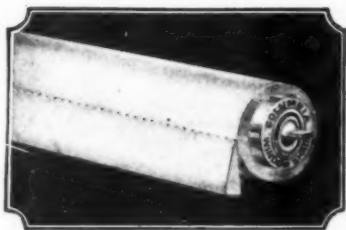
Of definite interest to hospitals is a new semi-heavy duty portable vacuum cleaner with dust blower attachment as illustrated, that was recently placed on the market. The machine is designed for institutions where the work is greater than can be accomplished by a small cleaner and yet is not of such an amount as to justify the purchase of the larger type of machine.

This cleaner can be used for removing light dust, by means of the blower attachment, from inaccessible places such as electric motor and apparatus, telephone switchboards or pianos which makes it adaptable for a wide range of service. It weighs a little over 100 pounds when ready for service and because of its compact design and its large, rubber tired wheels, can be easily transported up or down stairs by one person.

It is equipped with a one-half horse power motor, operated on direct current of 100 to 120 volts, or on alternating



Medical Arts Bldg., Portland, Oregon, is equipped with over 500 Columbia Window Shades. Houghtaling & Dougan, Architects.



Columbia Rollers are built to give satisfaction wherever they are used. They are always on the job. The fittings are nickel-plated, and there is reserve power in the spring that gives 30% to 40% longer life. An exclusive Columbia device is the self-lubricating feature which gives smooth, silent, clock-like operation so essential in hospital equipment.

You can save time and trouble and insure shade satisfaction by using the Standard Specification for Window Shades which we'll gladly send on request. A specimen roller and samples of Columbia Cloth are sent with the specification. Just fill in coupon and mail to The Columbia Mills, Inc., 225 Fifth Avenue, New York.

Name.....
Street.....
City..... R-9-26

No need to mark these window shades "Handle with care!"

"Please pull down that end shade, the light is too strong." "Put up the shades it's getting dark." "Be careful, you'll tear it," etc., etc. Petty distractions that tempt nurses' tempers and upset hospital routine. And all caused by window shades that are either dark and ugly, or made of cloth that ought to be marked "Handle with Care."

And all unnecessary, too!

For Columbia Window Shades are made to withstand the kind of treatment that ordinary shades are unable to endure. Especially suitable for hospitals is our Damasko Heavy Duty shade cloth—an unfilled cambric guaranteed not to crack. And the fine textured Damasko fabric comes in a variety of soft colors that subdue the hottest noonday sun—colors, too, that harmonize perfectly with both exterior and interior of any building.

Of equal importance is the roller. If it fails, or works indifferently, the life of any shade cloth is shortened. Columbia Rollers embody many exclusive refinements that give silent operation, and 30% to 40% longer life.

Let us send you, without obligation, our Standard Specifications for window shade purchase and installation, together with samples of Columbia shade cloth and a specimen Columbia Roller. Then you can judge their merit first hand. The coupon will bring them.

The Columbia Mills, Inc.

225 FIFTH AVENUE, NEW YORK

Boston Chicago Cincinnati Cleveland Detroit Pittsburgh
Kansas City Fresno New Orleans Philadelphia Portland (Ore.)
St. Louis San Francisco Minneapolis Los Angeles

Columbia **WINDOW SHADES and ROLLERS**

For complete index of advertisements refer to the Classified Directory

*On the
S.S.
Matsonia*



Steward Golden features ICED TEA HAWAIIAN

And here again we have a simple drink converted into a reputation-maker—just by adding Hawaii's "King of Fruits."

"Iced Tea" has a hot-weather appeal. "Iced Tea Hawaiian" is irresistible!

Try it! (Steward Alfred L. Golden very kindly offers his formula below.) It will please your patients—link up your establishment with the growing popularity of this delicious fruit—and add to your reputation as a purveyor of distinctive foods.

Iced Tea Hawaiian

Cut Sliced Hawaiian Pineapple into quarters. Put into iced tea glasses, half-filled with cracked ice and pour freshly-made tea over it. The hot tea brings out the flavor and makes a delicious and satisfying drink.

Pineapple Morning Glory

Mix $\frac{3}{4}$ cup juice from Canned Hawaiian Pineapple, 1 tablespoon honey, a pinch of salt and a tablespoon or more of lemon juice. This makes a delightful breakfast drink or cocktail. If preferred, the juice of an orange may be added.

Association of Hawaiian Pineapple Cannery

451 Montgomery Street, San Francisco, Calif.

HAWAIIAN PINEAPPLE

Sliced

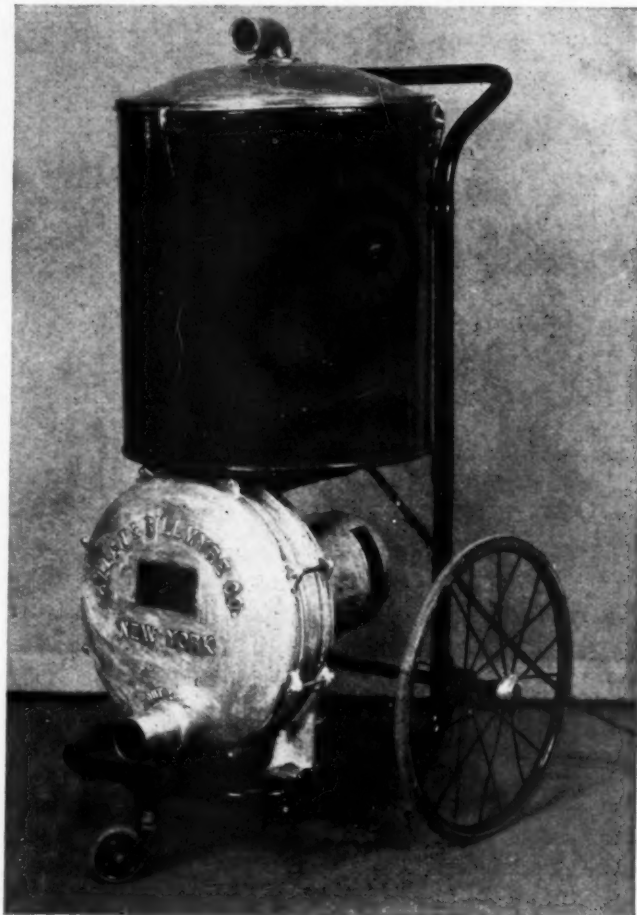
—For serving right from the can and for quick desserts and salads.



Crushed

—For sundae, ices, pies, cake filling, salads and hundreds of made-up dishes.

current of 105 to 120 volts, 25 to 60 cycles, single phase, from either lamp socket or floor plug connection. Special machines, operated on either type of current, may be had for 220 volts. The exhaustor is constructed entirely of



aluminum, the frame being of heavy steel tubing with all joints welded. The machine has an extreme height of forty-four inches, an extreme width of twenty-two and one-half inches, and an extreme length of twenty-seven inches.

READY CUT ABSORBENT GAUZE AND DRESSING ROLLS

Every improvement in construction, equipment, supplies and technique that has contributed in some measure to the better care of the sick, has invariably been adopted by hospitals. When first introduced the now commonly adopted bandage roll was accepted as an improvement. It offered economy in time and efficiency and speed in bandaging. Now a further improvement in the form of ready cut absorbent gauze and dressing rolls has been placed on the market.

This product retains all of the qualities of the old gauze and offers the following new features: It eliminates wasteful cutting and inaccuracies in size, it is always available in usable form, it is easy to dispense, and one or two sizes are sufficient for a majority of dressings.

The gauze is cut into squares and rectangles, in sizes most commonly used for sponges, pads, and dressings of all types in the hospital.

The ready cut dressing rolls eliminate difficult and inaccurate longitudinal folding; save time in preparing sponges; are especially adapted to use in long dressings; can be used for any gauze dressing whose completed width

The Body-Building Strength of Choicest Hops and Malt

Stored up in this unadulterated, uncolored, almost predigested LIQUID-FOOD-TONIC



Nature herself provides the curative, corrective, strength-giving qualities that make Malt-Nutrine so valuable an ally to conservative physicians in the treatment of nursing mothers, convalescent patients, and those who are overworked or undernourished.

The nutritive value of this famous Liquid-Food-Tonic is evident from the following comparative analysis:

	Water	Total Solids
Milk	87.3%	12.7%
Eggs—edible portion ..	72.8%	27.2%
Veal	73.0-76.0%	24.0-27.0%
Malt-Nutrine	71.0-72.0%	25.0-26.0%

Malt-Nutrine is a highly concentrated tonic prepared under a special permit from the Government and distributed under pure food permit No. H-14071. It has been classified as a pure malt product by the U. S. Department of Internal Revenue.

Its principal ingredient is a pure malt extract of selected Northern barley—and from the beginning of history, barley has always been recognized as man's most nutritious food.

Malt-Nutrine is also rich in "Nature's Greatest Aromatic Bitter Tonic"—hops. Shoemaker, one of the world's standard medical authorities, points out that "The bitter principle of hops acts as a stimulant on the stomach, causing an active secretion of the gastric juices."

The soothing, quieting effects of Malt-Nutrine come from a third ingredient—a fine powder "lupulin," found on the hop plant and extensively prescribed in the treatment of nervous diseases.

The process used to bring the hop extract and protein from the malt in the most palatable form develops a small percentage of alcohol—4.15% by volume. This amount of alcohol assures the proper preservation of Malt-Nutrine, and has a material bearing on its easy and thorough assimilation.

Malt-Nutrine has been heartily endorsed by prominent physicians and hospital authorities during the past thirty years. Any additional information you may wish regarding it will be furnished gladly on request.



Anheuser-Busch , , , St. Louis

ANHEUSER-BUSCH'S
Malt-Nutrine
REG. U.S. PAT. OFF. TRADE MARK

It meets the dictates of modern medical practice

KELLOGG'S ALL-BRAN is most widely employed to relieve constipation—but it is equally valuable in **preventing** constipation and promoting regular, natural elimination of the intestinal tract. Preventive medicine of the highest order!

Physicians recognize in Kellogg's ALL-BRAN a valuable aid and ally in combating the evil of constipation. They know that Kellogg's is 100% bran and for that reason they can rely upon its accomplishing definite, complete results. That is why ALL-BRAN is recommended by so many of the profession in both mild and chronic cases.

Patients like Kellogg's ALL-BRAN and like to "take it." Kellogg's is cooked and krumbled by a special process that gives it a delicious, nut-like flavor. A delightful breakfast dish. There are countless appetizing ways of serving it.

Sold by all grocers. Served everywhere. Made by Kellogg in Battle Creek, Michigan.



What U.S.P. is to
drugs, ALL-BRAN
is to bran foods.

Send to the Kellogg Company,
Battle Creek, Mich., for recipes
and health pamphlets.

Kellogg's
the original ALL-BRAN
—ready-to-eat

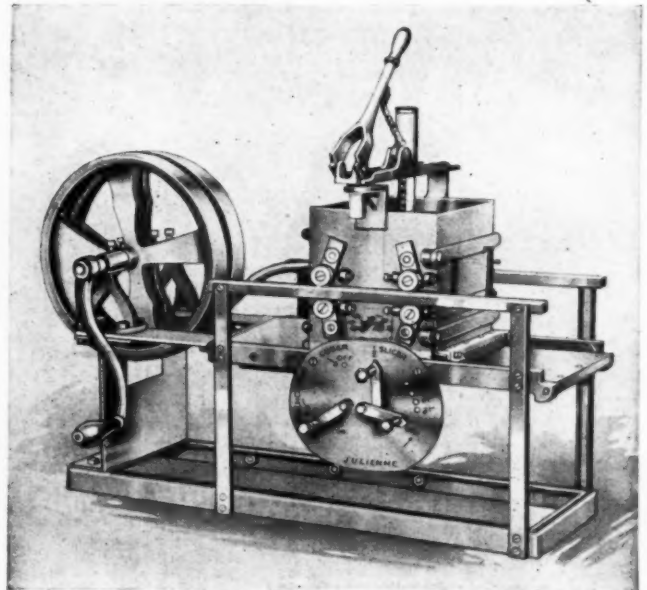
is either nine or four and one-half inches; and reduce the nonprofessional work of the nurse.

These rolls may be secured in 100-yard lengths, thirty-six inches in width, folded in two sizes; 4-ply (nine inch roll) and 8-ply (four and one-half inch roll).

They are so folded that both selvages are inside and when the ends are tucked in, the dressing cannot come apart.

AN AUTOMATIC FOOD CUTTER

An automatic food cutter for quickly cutting, slicing or cubing potatoes and other vegetables, and which does not crush, force or squeeze the foods although large quantities are cut at one time, has recently been developed by a western manufacturer. The machine is operated by filling a peck capacity hopper, shown in the accompanying illustration, setting the indicator for the desired cut, and



turning the handle as rapidly as deemed necessary. There is no limit on the speed at which the handle is rotated.

The cutter is made of solid brass, steel and German silver. All parts are thickly tinned and will withstand vegetable acids, while the knives in the hopper which cut the vegetables are of stainless steel. The machine is quietly operated, having adjustable hardened roller bearings of brass which run on steel bars, avoiding noise and facilitating easy motion.

A PORTABLE MILK DISPENSER

To meet the need of a sanitary milk dispenser in which milk may be carried as well as served, especially in hospitals where the centralized food service system is in vogue, a two-gallon portable milk dispenser that assures sanitary milk because of its tightly fitting cover, has lately been developed. The dispenser, made of aluminum with a seamless, double wall, cork filled construction which insures maintenance of proper temperature, may be placed on the food cart, and dining room table, or carried through the ward by means of a bail handle.

The faucet and float tube arrangement allows a uniform percentage of butter fat in every glass. The convenient size of the dispenser, which has an outside diameter of ten inches and a height of thirteen inches, facilitates easy sterilization in the ordinary utensil sterilizer if desired.

"PYREX" flasks and
beakers are standard
equipment every-
where.

In the
Hospital Laboratory
the glassware used
must be dependable



BREAKAGE of laboratory glassware is always an annoyance—and often becomes an item of considerable expense.

But in the hospital laboratory the breaking of a piece of glassware—and the loss of its contents—may have much more serious, more far-reaching effects than time and effort wasted.

Hospital authorities, as well as leading industrial research chemists, recognize the unquestioned superiority of Pyrex laboratory ware under exacting conditions.

Highly resistant to extreme heat, to sudden cooling and to breakage in handling, and of high chemical stability, *Pyrex is used wherever absolute dependability is vital.*

* * *

But Pyrex is also the most practical equipment to use for daily routine work. Due to its remarkably low coefficient of expansion, Pyrex ware can be made much heavier, much sturdier than ordinary apparatus. It will stand up under constant handling, constant sterilizing—will be giving service long after other glassware would have been replaced several times.

Further information regarding the many hospital uses for Pyrex will be furnished upon request.

CGW

CORNING GLASS WORKS
Corning, New York

PYREX OVENWARE

Tests by experts have shown that foods actually *bake better, more evenly*, in Pyrex ovenware. In the diet kitchen, the convenience of baking and serving in the same dish, the greater ease of keeping Pyrex spotlessly clean, mean greater efficiency. *And foods keep hot longer in Pyrex.*

PYREX NURSING BOTTLES

Like all Pyrex ware, these nursing bottles will not break nor crack during sterilization. Made in wide mouth and narrow neck styles.





J. N. Adam Memorial HOSPITAL CASTER

A two-in-one caster that does double duty. The horizontal wheel acts as a revolving, rubber-tired buffer. It fends off the bed posts from walls, door casings and furniture. Rugged construction to hold up under severest usage.

Malleable Fork Pressed Steel Wheel

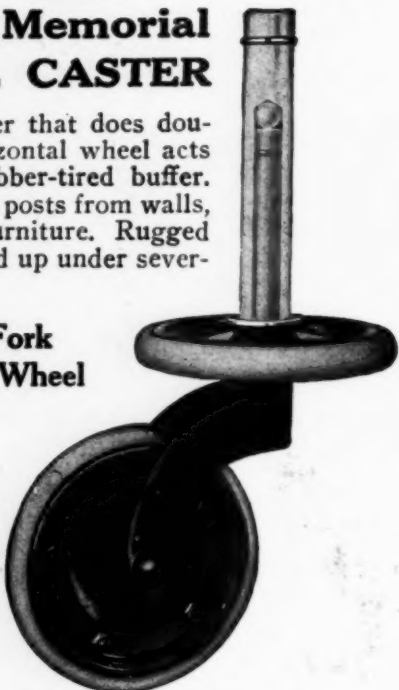
This type of caster-fender can be made to meet special requirements, with different length stems and wheel sizes. It is noiseless, easy running and practically unbreakable. Has renewable J & J clincher type rubber tires. Write for samples and prices.

We will exhibit at the Atlantic City Convention.
Call at our Booth No. 38.

JARVIS & JARVIS

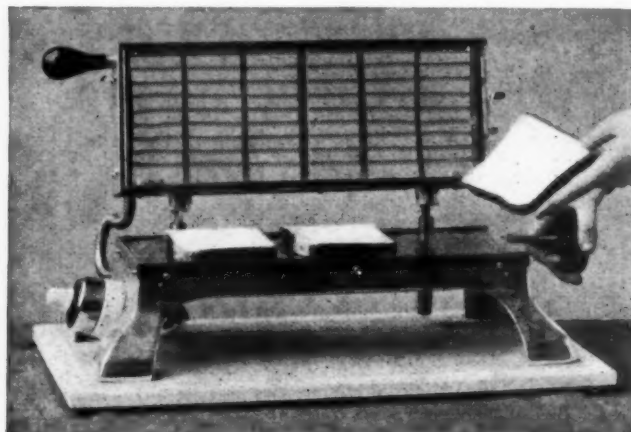
102 Pleasant St.

PALMER, MASS.



A TRANSPARENT TOASTER

A transparent toaster that permits the operator to watch the bread during the toasting process, has recently been placed on the market. The glass top, enclosed in a metal frame that fits so snugly over the lower plate that no

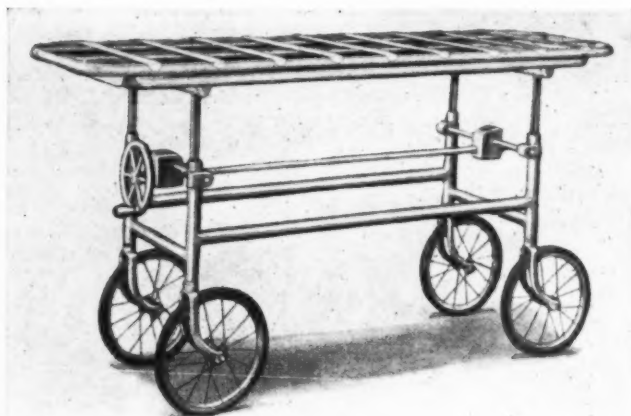


heat escapes, affords a view of the bread which assures neither overdone nor underdone toast. This glass top is the only material with which the bread comes in contact during the operation of toasting.

This simple heating apparatus, shown in the accompanying illustration, is made of nichrome wire and may be attached to any lamp socket. The toaster will accommodate three sandwiches, rolls, or slices of bread.

THE ELIMINATION OF LIFTING

The adjustable wheel stretcher shown in the illustration serves the double purpose of eliminating strain on the patient following an operation and relieving the nurses of the strain of lifting the patient. By the use of geared rods within the four legs the stretcher may be raised to the height of the operating table or lowered to the



height of the bed. This stretcher has recently been made available to the hospital field.

The carriage frame is built of tubular steel and all points are welded. The wheels are twelve inches in diameter with one-inch rubber tires, and are equipped with ball bearings. The wheels swivel on forks operating on ball bearings, which allows the stretcher to be moved laterally, thus making it easier to approach the operating table or bed without straining the wheels. The detachable top is seventy-two inches long by twenty-one inches wide and may be provided with a rubber cushion guard to protect doorways and halls.

LOCKE-STEVENSON CORPORATION BOOTH
A-1 PLUMBING GOODS 172
100 WARRENTON STREET A. H. A.
BOSTON



PLATE 1005—LAVATORY FOR PRIVATE ROOMS

Porcelain enameled iron. Plain slab. No integral overflow. Supply fixture through back. Elbow action valves. High single spout delivery. Large white removable overflow. White glass shelf with towel bar supports.

A child and a sick person have much in common



Always look
for the name
"Canada Dry"
on the bottle
cap to be sure
of the original



Think back to your childhood and you'll remember this grievance. It just seemed as though everything you particularly liked "wasn't good for you." Many sick people find that the things they particularly enjoy are denied them. Food in the sick room must be so carefully selected for purity that often the diet tends to monotony.

In this connection "Canada Dry" offers you a double opportunity. You add another article to your "pure" list. And you give the patient something he enjoys—a beverage that is highly relished, yet good for him.

The purity of "Canada Dry" is carefully guarded. Every ingredient is scientifically tested in a laboratory maintained for that purpose. The water, the sugar, the fine Jamaica ginger (no capicum is ever used) must all pass rigid inspection. Only new, sterile bottles are used. No human hands ever touch "Canada Dry" until after the cool, green bottles are tightly sealed and wrapped with foil.

Most of the great hospitals of the United States and Canada appreciate the absolute purity of "Canada Dry." Their confidence in it is shown by its exclusive use in so many of them.

We will gladly send a sample bottle to hospital superintendents and dietitians.

“CANADA DRY”

Reg. U. S. Pat. Off.

Does Not Contain Capsicum

Extract imported from Canada and bottled in the U. S. A. by Canada Dry Ginger Ale, Incorporated, 25 W. 43rd St., New York. In Canada, J. J. McLaughlin Limited, Toronto. Established 1890.

(c) 1926

OUT of more than fifty makes of weatherstrips on the market, only one automatically adjusts itself to the constant swelling, shrinking and warping of the sash and frame of a window.

That one is the Monarch Self-Adjusting type.

This explains the amazing results of that series of more than 600 tests of the two standard types of weather strips recently conducted by two national organizations at the U. S. Bureau of Mines Building in Pittsburgh, Pa.

Those tests proved that Monarch Self-Adjusting Metal Weather Strips give 58% greater protection against inleaking air than any other strip tested.

Mail the coupon for interesting booklet which tells the whole story. This booklet is free.

Monarch Metal Products Co.

4960 Penrose St.

St. Louis, Mo.

Manufacturers of Monarch Metal Weather Strips for Wood Windows and Doors.

Representatives in All Principal Cities

Monarch Metal Products Co.,
4960 Penrose Street,
St. Louis, Mo.

Please send me complete information regarding Monarch Metal Weather Strips for hospitals.

Name.....

Address.....

Book Reviews and Current Hospital Literature

HYDROGEN ION CONCENTRATION OF THE BLOOD IN HEALTH AND DISEASE

By J. HAROLD AUSTIN, Professor of Research Medicine, University of Pennsylvania, Philadelphia; and Glenn E. Cullen, Professor of Biochemistry, Vanderbilt University, Nashville, Tenn.¹

Medicine monographs are comprehensive reviews of current medical subjects that adequately discuss a disease, certain aspects of a disease, or subjects allowing a better comprehension of disease processes.

Among the newer advances in the methods applicable to the study of disease and the mechanism of its manifestations are the methods of the newer, colloidal chemistry.

The development of the methods for measuring hydrogen ion concentration has led to many studies of the significance of variations of the hydrogen ion concentration of the blood in health and disease, and in the present volume, Austin and Cullen have sought to present in concise and simple form the most important facts so far available.

The volume is intended for the use of the clinician as well as the laboratory worker and should prove useful to both.

The survey presented is neither an exhaustive review nor a critical analysis but is planned to include only the work done by more recent methods and, at the same time, of clinical importance.

In the first chapter the subject of hydrogen ion concentration is discussed in a general and explanatory way. Chapter two is concerned with normal PH values of blood and other body fluids. Chapter three discusses the PH of the plasma in disease, a number of varied conditions being covered, and the last chapter is concerned with a brief and explanatory review of acceptable methods.

Considering the obtruse nature of the subject, the text is clear and readable.

This book contains a wealth of information and should be in the library of every clinician as well as laboratory worker.—R. A. K.

SUSQUEHANNA

By FREDERIC BRUSH, M.D., Medical Director, Burke Foundation, White Plains, N. Y.²

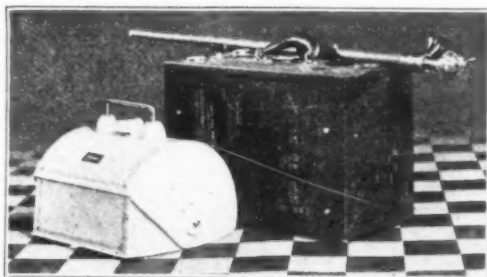
The delightful volume of poetical tone pictures and sketches by Dr. Brush is pleasant reading even for those who are unfamiliar with the Susquehanna River and valley which he portrays with the ability not usually found in those who write as a diversion from the duties of medical director. His verses are especially dear to those who are familiar with the bit of country and people he describes.

1. Medicine Monograph VIII. Williams & Wilkins Co., Baltimore, Md., 1926.
2. The Moser Press, Portland, Me.



It is gratifying to announce
the first Portable Quartz Lamp
-an exclusive Burdick Creation
of extraordinary precision and
beauty

F. F. Burdick



The New Burdick Portable Quartz Lamp operates on A. C. or D. C. Current—is equipped with voltmeter and voltage regulator—and is instantly portable when desired.



Creators of

BURDICK
AIR-COOLED QUARTZ LAMPS

BURDICK
WATER-COOLED QUARTZ LAMPS

BURDICK
ZOALITE INFRA RED GENERATORS

The
BURDICK CORPORATION
FORMERLY THE BURDICK CABINET COMPANY
MILTON, WISCONSIN

Creators of

BURDICK
QUARTZ APPLICATORS

BURDICK
LIGHT BATH CABINETS

BURDICK
DEEP THERAPY LAMPS

DISTRIBUTORS IN ALL THE PRINCIPAL CITIES OF THE UNITED STATES AND CANADA



An economical food for hospital use

—listed by the Boston Dietetic Bureau

First, food quality—then economy. Isn't that the way you buy food for your kitchens?

First of all, of course, you must have food which provides essential nourishment in a form which can be handled by delicate digestions.

The Dietetic Bureau of Boston has compiled a table of such foods with reference to economy. In this table, Cream of Wheat is featured as an "economical food for hospital use."

Out of one box of Cream of Wheat you can get 40 generous servings. This makes the cost per serving less than 1c!

Another economy of Cream of Wheat is that there is never any danger of spoilage. It is protected by a sterilizing heat process and by a triple-wrapped-and-sealed package from any outer impurities. Summer or winter, you can depend upon its uniform quality.

Physicians like Cream of Wheat because it is so rich in the carbohydrate value invalids, babies and children need, and because it is so easy to digest.

Your patients will like the delicious creaminess of this food, served as a cereal or in combination dishes. We suggest here one of the many delightful ways to serve it, to tempt uncertain appetites. We will gladly send you, free, our recipe book, "50 Ways of Serving Cream of Wheat."

Date Pudding

$\frac{1}{2}$ cup of Cream of Wheat	$\frac{1}{2}$ cup of sugar
3 cups of milk	$\frac{1}{2}$ cup chopped dates
$\frac{1}{4}$ teaspoon of salt	$\frac{1}{2}$ teaspoon of vanilla
3 eggs	

Cook milk, Cream of Wheat and salt in double boiler for fifteen minutes. Add yolks of eggs beaten with sugar. Cook until thickened. Add dates. Remove from fire and pour over stiffly beaten whites. Add vanilla, mix thoroughly and serve cold with whipped cream.

FOR 30 YEARS A STANDARD FOOD ON
PHYSICIANS' DIET LISTS

Cream of Wheat

Cream of Wheat Company, Minneapolis, Minnesota
In Canada, made by Cream of Wheat Company, Winnipeg

© 1926, C. of W. Co.

NEWS OF THE HOSPITALS

California

The purchase of a 178 acre tract by the state for a truck and vegetable garden for the Agnew State Hospital, Agnew, was recently announced by Dr. Leonard E. Stocking, superintendent of the institution.

Construction work on the first two buildings of the new St. Vincent's Hospital group, Los Angeles, will be completed by October 1, according to a recent announcement. The main hospital building, which will have accommodations for 250 beds, and the combined laundry room and boiler house are the buildings being erected.

The city of Pasadena is making preparations to renovate the Isolation Hospital of the city for the accommodation of patients suffering from contagious diseases. The work was delayed because of the controversy over the zoning ordinance.

Construction work under the supervision of Major W. H. Radcliffe, construction engineer for the U. S. Veterans' Bureau, has commenced on additional buildings at the U. S. Veterans' Bureau Hospital, Palo Alto.

Wooden buildings at the U. S. Veterans' Bureau Hospital, Palo Alto, are being razed in preparation for the construction of new additions to the hospital plant for which an appropriation of \$800,000 was recently made by Congress.

Colorado

The Initial tuberculosis unit in the \$2,000,000 project of the Methodist Episcopal church at Colorado Springs was opened on August 2. The building contains fifty-five rooms, twenty-two of which are already reserved.

Connecticut

A bequest of \$500,000 and a share in the residuary estate has been given to the Charlotte Hungerford Hospital, Torrington, by the will of the late U. T. Hungerford.

Florida

A three-day postgraduate short course on the diagnosis and treatment of gonorrhea and syphilis was held recently at the Duval County Hospital, Jacksonville, according to Fred Walker, superintendent.

Georgia

According to Dr. Charles C. Jarrell, Atlanta, Ga., a representative hospital will be erected in New Orleans by the Methodist Episcopal Church South. Tentative plans provide for the construction of an initial unit of 100 beds.

Indiana

According to a recent report by Dr. St. C. Darden, superintendent, the maintenance of the Healthwin Tuberculosis Hospital, South Bend, for the month ending June 20 was \$7,555.55 for the 110 patients accommodated at the institution. This amounts to a net cost of two dollars a day for each patient.

HOW TO FIND OUT

If you want to know what firm can best serve you in raising the funds needed for that new hospital building why not follow the example of Dr. F. H. Pratten, Medical Superintendent of the Queen Alexandra Sanatorium, at London, Ontario, which desired to raise \$500,000 as endowment in memory of the beloved founder of that institution, the late Sir Adam Beck? At the close of the campaign, Dr. Pratten wrote as follows:

"Before deciding to employ your firm we made enquiries from a number of organizations for whom you had conducted similar campaigns, and we received in all twenty-four most favorable replies. We can now quite concur in their recommendation."

	Objective	Secured
Fifth Avenue Hospital, New York City.....	\$2,000,000	\$1,850,000
Post Graduate Hospital, New York City.....	2,000,000	1,600,000
Reading Hospital, Reading, Pa.....	1,800,000	1,813,000
United Hospital, Rochester, N. Y.....	1,300,000	1,395,000
Arnot-Ogden Hospital, Elmira, N. Y.....	800,000	901,024
Union Protestant Infirmary, Baltimore, Md.....	750,000	810,000
Flushing Hospital, Flushing, N. Y.....	750,000	803,000
American Hospital of Paris, France (3 campaigns).....	500,000	950,000
Washington Hospital, Washington, Pa.....	500,000	523,000
Miami Valley Hospital, Dayton, Ohio.....	500,000	515,000
Methodist Hospital, Fort Worth, Texas.....	500,000	502,512
Presbyterian Hospital, Denver, Colo.....	500,000	500,000
Stanford University Hospital, San Francisco.....	500,000	500,000
Maryland General Hospital, Baltimore (3 campaigns).....	450,000	483,000
Paterson General Hospital, Paterson, N. J.....	400,000	450,000
St. Mary's Hospital, Grand Rapids, Mich.....	350,000	384,316
Framingham Hospital, Framingham, Mass.....	350,000	352,585
Memorial Hospital, Pawtucket, R. I.....	300,000	422,190
Sturdy Memorial Hospital, Attleboro, Mass.....	300,000	390,500
Children's Hospital, St. Louis, Mo.....	300,000	330,000
Mercy Hospital, Pittsfield, Mass.....	250,000	328,000
Cape Cod Hospital, Hyannis, Mass. (2 campaigns).....	280,000
Toronto Western Hospital, Toronto, Canada.....	210,000
St. Mary's Hospital, Rochester, N. Y.....	225,000	344,890
Norwood Hospital, Norwood, Mass.....	200,000	260,000
Marietta General Hospital, Marietta, Ohio.....	250,000	253,000
Southside Hospital, Bayshore, Long Island, N. Y.....	200,000	230,000
White Plains Hospital, White Plains, N. Y.....	200,000	200,000
St. Lawrence Hospital, Lansing, Mich.....	200,000	206,000
Maternity & Children's Hospital, Toledo, Ohio.....	150,000	158,500
Methodist Hospital, Sioux City, Iowa.....	125,000	153,500
Pottsville Hospital, Pottsville, Pa.....	100,000	120,000
Hayswood Hospital, Maysville, Ky.....	100,000	116,800
Saratoga Hospital, Saratoga Springs, N. Y.....	100,000	116,000
Evangelical Deaconess Hospital, Freeport, Ill.....	100,000	105,000
Ogdensburg City Hospital and Orphanage, N. Y.....	75,000	123,369
United Helpers Home, Ogdensburg, N. Y.....	75,000	116,000
Dobbs Ferry Hospital, Dobbs Ferry, N. Y.....	75,000	116,019
St. Francis Hospital, Poughkeepsie, N. Y.....	75,000	100,000
St. Francis Hospital, Port Jervis, N. Y.....	75,000	80,000
Shenandoah Hospital, Shenandoah, Pa.....	70,000	110,000

We will gladly send a representative to confer on your financial problems without obligation or cost to you.

WARD, WELLS, DRESHMAN AND GATES

NEW YORK: 475 Fifth Avenue CHICAGO: 612 Wrigley Building

Originators of the Intensive Method of Fund Raising



An economical food for hospital use

—listed by the Boston Dietetic Bureau

First, food quality—then economy. Isn't that the way you buy food for your kitchens?

First of all, of course, you must have food which provides essential nourishment in a form which can be handled by delicate digestions.

The Dietetic Bureau of Boston has compiled a table of such foods with reference to economy. In this table, Cream of Wheat is featured as an "economical food for hospital use."

Out of one box of Cream of Wheat you can get 40 generous servings. This makes the cost per serving less than 1c!

Another economy of Cream of Wheat is that there is never any danger of spoilage. It is protected by a sterilizing heat process and by a triple-wrapped-and-sealed package from any outer impurities. Summer or winter, you can depend upon its uniform quality.

Physicians like Cream of Wheat because it is so rich in the carbohydrate value invalids, babies and children need, and because it is so easy to digest.

Your patients will like the delicious creaminess of this food, served as a cereal or in combination dishes. We suggest here one of the many delightful ways to serve it, to tempt uncertain appetites. We will gladly send you, free, our recipe book, "50 Ways of Serving Cream of Wheat."

Date Pudding

$\frac{1}{2}$ cup of Cream of Wheat	$\frac{1}{2}$ cup of sugar
3 cups of milk	$\frac{1}{2}$ cup chopped dates
$\frac{1}{4}$ teaspoon of salt	$\frac{1}{2}$ teaspoon of vanilla
3 eggs	

Cook milk, Cream of Wheat and salt in double boiler for fifteen minutes. Add yolks of eggs beaten with sugar. Cook until thickened. Add dates. Remove from fire and pour over stiffly beaten whites. Add vanilla, mix thoroughly and serve cold with whipped cream.

FOR 30 YEARS A STANDARD FOOD ON
PHYSICIANS' DIET LISTS

Cream of Wheat

Cream of Wheat Company, Minneapolis, Minnesota
In Canada, made by Cream of Wheat Company, Winnipeg

© 1926, C. of W. Co.

NEWS OF THE HOSPITALS

California

The purchase of a 178 acre tract by the state for a truck and vegetable garden for the Agnew State Hospital, Agnew, was recently announced by Dr. Leonard E. Stocking, superintendent of the institution.

Construction work on the first two buildings of the new St. Vincent's Hospital group, Los Angeles, will be completed by October 1, according to a recent announcement. The main hospital building, which will have accommodations for 250 beds, and the combined laundry room and boiler house are the buildings being erected.

The city of Pasadena is making preparations to renovate the Isolation Hospital of the city for the accommodation of patients suffering from contagious diseases. The work was delayed because of the controversy over the zoning ordinance.

Construction work under the supervision of Major W. H. Radcliffe, construction engineer for the U. S. Veterans' Bureau, has commenced on additional buildings at the U. S. Veterans' Bureau Hospital, Palo Alto.

Wooden buildings at the U. S. Veterans' Bureau Hospital, Palo Alto, are being razed in preparation for the construction of new additions to the hospital plant for which an appropriation of \$800,000 was recently made by Congress.

Colorado

The Initial tuberculosis unit in the \$2,000,000 project of the Methodist Episcopal church at Colorado Springs was opened on August 2. The building contains fifty-five rooms, twenty-two of which are already reserved.

Connecticut

A bequest of \$500,000 and a share in the residuary estate has been given to the Charlotte Hungerford Hospital, Torrington, by the will of the late U. T. Hungerford.

Florida

A three-day postgraduate short course on the diagnosis and treatment of gonorrhea and syphilis was held recently at the Duval County Hospital, Jacksonville, according to Fred Walker, superintendent.

Georgia

According to Dr. Charles C. Jarrell, Atlanta, Ga., a representative hospital will be erected in New Orleans by the Methodist Episcopal Church South. Tentative plans provide for the construction of an initial unit of 100 beds.

Indiana

According to a recent report by Dr. St. C. Darden, superintendent, the maintenance of the Healthwin Tuberculosis Hospital, South Bend, for the month ending June 20 was \$7,555.55 for the 110 patients accommodated at the institution. This amounts to a net cost of two dollars a day for each patient.

HOW TO FIND OUT

If you want to know what firm can best serve you in raising the funds needed for that new hospital building why not follow the example of Dr. F. H. Pratten, Medical Superintendent of the Queen Alexandra Sanatorium, at London, Ontario, which desired to raise \$500,000 as endowment in memory of the beloved founder of that institution, the late Sir Adam Beck? At the close of the campaign, Dr. Pratten wrote as follows:

"Before deciding to employ your firm we made enquiries from a number of organizations for whom you had conducted similar campaigns, and we received in all twenty-four most favorable replies. We can now quite concur in their recommendation."

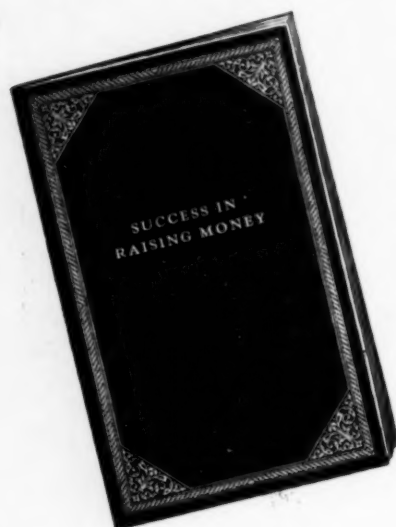
	Objective	Secured
Fifth Avenue Hospital, New York City.....	\$2,000,000	\$1,850,000
Post Graduate Hospital, New York City.....	2,000,000	1,600,000
Reading Hospital, Reading, Pa.....	1,800,000	1,813,000
United Hospital, Rochester, N. Y.....	1,300,000	1,395,000
Arnot-Ogden Hospital, Elmira, N. Y.....	800,000	901,024
Union Protestant Infirmary, Baltimore, Md.....	750,000	810,000
Flushing Hospital, Flushing, N. Y.....	750,000	803,000
American Hospital of Paris, France (3 campaigns).....	500,000	950,000
Washington Hospital, Washington, Pa.....	500,000	523,000
Miami Valley Hospital, Dayton, Ohio.....	500,000	515,000
Methodist Hospital, Fort Worth, Texas.....	500,000	502,512
Presbyterian Hospital, Denver, Colo.....	500,000	500,000
Stanford University Hospital, San Francisco.....	500,000	500,000
Maryland General Hospital, Baltimore (3 campaigns).....	450,000	483,000
Paterson General Hospital, Paterson, N. J.....	400,000	450,000
St. Mary's Hospital, Grand Rapids, Mich.....	350,000	384,316
Framingham Hospital, Framingham, Mass.....	350,000	352,585
Memorial Hospital, Pawtucket, R. I.....	300,000	422,190
Sturdy Memorial Hospital, Attleboro, Mass.....	300,000	390,500
Children's Hospital, St. Louis, Mo.....	300,000	330,000
Mercy Hospital, Pittsfield, Mass.....	250,000	328,000
Cape Cod Hospital, Hyannis, Mass. (2 campaigns).....	280,000
Toronto Western Hospital, Toronto, Canada.....	210,000
St. Mary's Hospital, Rochester, N. Y.....	225,000	344,830
Norwood Hospital, Norwood, Mass.....	200,000	260,000
Marietta General Hospital, Marietta, Ohio.....	250,000	253,000
Southside Hospital, Bayshore, Long Island, N. Y.....	200,000	230,000
White Plains Hospital, White Plains, N. Y.....	200,000	200,000
St. Lawrence Hospital, Lansing, Mich.....	200,000	206,000
Maternity & Children's Hospital, Toledo, Ohio.....	150,000	158,500
Methodist Hospital, Sioux City, Iowa.....	125,000	153,500
Pottsville Hospital, Pottsville, Pa.....	100,000	120,000
Hayswood Hospital, Maysville, Ky.....	100,000	116,800
Saratoga Hospital, Saratoga Springs, N. Y.....	100,000	116,000
Evangelical Deaconess Hospital, Freeport, Ill.....	100,000	105,000
Ogdensburg City Hospital and Orphanage, N. Y.....	75,000	123,369
United Helpers Home, Ogdensburg, N. Y.....	75,000	116,000
Dobbs Ferry Hospital, Dobbs Ferry, N. Y.....	75,000	116,019
St. Francis Hospital, Poughkeepsie, N. Y.....	75,000	100,000
St. Francis Hospital, Port Jervis, N. Y.....	75,000	80,000
Shenandoah Hospital, Shenandoah, Pa.....	70,000	110,000

We will gladly send a representative to confer on your financial problems without obligation or cost to you.

WARD, WELLS, DRESHMAN AND GATES

NEW YORK: 475 Fifth Avenue CHICAGO: 612 Wrigley Building

Originators of the Intensive Method of Fund Raising



**Success in
raising money
is largely
determined
by the degree
of intelligence
exercised in
selecting an
organization to
raise it.**

**If you would
be guided by
ability and
experience
send for the
above booklet.
It's free.**

THE HERBERT B. EHLER COMPANY
Twelve East Forty-First Street
NEW YORK

Iowa

A new \$300,000 structure will supplant the present Mercy Hospital, Burlington, the construction work on the new six-story building to be commenced early in 1927.

At a meeting of the board of directors of the Maternity Hospital, Sioux City, it was decided to rescind the action of July 1, closing the institution. The hospital will reopen following the renovation of the structure and the installation of new equipment.

The Eleanor Moore County Hospital, Boone, was recently opened to the public following the renovation of the structure which was damaged by fire a year ago.

Kentucky

Equipment and supplies for the new government trachoma hospital to be located at Richmond, have already been received and the hospital will be opened during early September, according to Dr. P. B. Mossman of the public health service, Lexington, Ky.

Maine

The Maine General Hospital, Portland, recently received a bequest of \$100,000 from Cyrus H. K. Curtis, Philadelphia publisher. Donations totaling \$100,000 were also received from four other donors.

Massachusetts

Following the donation of \$75,000 for the erection of a new nurses' home for the North Adams Hospital, North Adams, by H. W. Clark, the board of directors of the institution decided to remodel the present nurses' home for the use of the maternity department.

Michigan

Plans have been prepared for the addition of a new wing to the Wade Memorial Hospital, Coldwater.

Fire in a small building adjacent to the Detroit Tuberculosis Sanatorium, Detroit, caused fifteen patients to be removed to safety recently. The fire was quickly brought under control without causing damage to the hospital structure.

Minnesota

Plans for a new \$60,000 hospital at Proctor are being prepared by the Duluth, Missabe and Northern Railroad to replace the old hospital building.

Actual construction work on the new \$200,000 addition to St. Joseph's Hospital, Mankato, began during early July.

Ground was recently broken for the construction of the new \$1,300,000 hospital at St. Cloud, for the Sisters of the Order of St. Benedict. The six-story building will be completed within two years, according to the present plans.

Missouri

Following action at a recent meeting of the Frisco Employees Hospital Association at Springfield, Mo., a \$500,000 hospital for the employees of the railroad will be built in that city.

The new building for the Kent General Hospital, South Dover, was turned over to the building committee July 22. The hospital will be completely furnished before December.

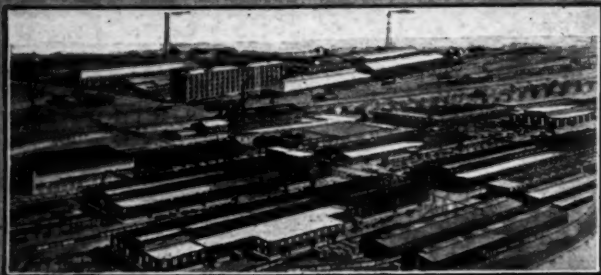
Karo Syrup is the ideal sugar supplier for the infant, the older child, the adolescent and for such among the adults as may require a reinforcement of carbohydrate or sugar nutrition.

AS a quickly and completely available form of converted carbohydrate and as a nutritive element of decided potency and universal tolerability, KARO SYRUP is a distinctly valuable addition to the diet of either child or adult requiring heat and energy-producing, readily oxidizable pabulum.

KARO SYRUP is the ideal Dextrose and Dextrin containing agent for all classes, ages and conditions of people, but peculiarly so for those whose starch and sugar-converting functions are either in partial or more or less complete abeyance.

Karo is the Corn Syrup now being prescribed for Infant Feeding—not only because of its high Dextrose and Dextrin content—but because parents can secure Karo from grocers in every village, town and city in every State of the U. S. A.





Bought by Men Who Know

Certain men by education, training and natural bent are better fitted than other men to judge the value of hot water heaters.

The engineers of the American Locomotive Company are such men, because of their experience in building locomotives. And when this big concern needed hot water heaters for their enormous Schenectady plant they chose

Patterson Hot Water Heaters

With all the expert knowledge of the American Locomotive Company at their command, would they have invested in a make of hot water heaters that they did not know to be the best?

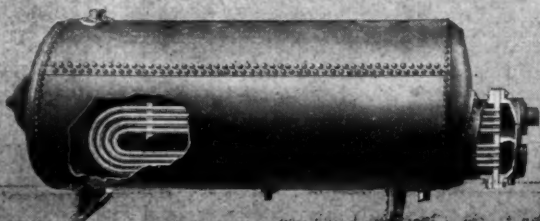
Men who are engineers, technical experts—men who build boilers themselves—buy on the strength of their own sufficient knowledge. You could not mislead them if you wanted to.

When you install "Patterson" Hot Water Heaters, your judgment is backed by thousands of men who know that Patterson Heaters are efficient and durable because of their mechanical training, as well as men who know from the service these heaters have given over a period of 45 years.

Write for copy of our catalog.

Patterson & Kelley Co.

101 Park Avenue
NEW YORK CITY



New York

The campaign for \$1,000,000 for the erection and maintenance of the buildings of the Flushing Hospital, Flushing, has been extended in order to allow the teams handling the drive to secure \$185,000 necessary to complete the fund at the end of the campaign.

Enlarged services will be available at the Knickerbocker Hospital, New York, following the completion of the new wing now under construction. An obstetrical and nose and throat clinic will be included in the new six-story unit which will accommodate 150 beds.

A tract of 121 acres has been purchased with funds provided by the state as a site for the new power plant and railroad spur for the new \$2,000,000 unit of the Matteawan State Hospital, Beacon, which is now under construction.

The new \$110,000 Municipal Hospital, Erie, is rapidly nearing completion, according to John Schreck, director of public safety. The new three-story structure will have a capacity of 60 beds and will be under the charge of Mrs. George Fleming who has been superintendent at the old Municipal Hospital.

The Erie County Hospital, Buffalo, will soon be located in its new buildings at Alden, according to Dr. John D. Howland, superintendent. New equipment is being installed in the new hospital buildings. The old hospital structure will be remodeled for use as classrooms for the University of Buffalo.

According to the will of the late Mrs. Mary Clark, the New York Hospital for Women and Children, New York, will receive \$300,000 direct and also a contingent bequest of \$1,270,000 from the same source.

Construction work recently began on the new seventy-five bed sanitarium for vaudeville artists at Spion Kop, Saranac Lake. The two-story structure will be ready for occupancy during the summer of 1927.

Tentative plans for the campaign for funds for the new Syracuse Memorial Hospital, Syracuse, have been arranged. The new hospital building will be erected as a unit in the proposed medical center of Syracuse.

Contracts were recently awarded for the construction of the Parmley and Ogden Hospital, Electra. The hospital is to be a three-story structure with a capacity of twenty-five beds.

Construction work has commenced on the new Elks Hospital, Mercedes, which will have a capacity of twenty-eight beds.

The cornerstone of the first unit of the Knights of Columbus Sanitarium being erected at Gabriels Sanitarium, Saranac Lake, was laid July 11. Construction work on additional units is under way.

The new Municipal Hospital, built in connection with the Strong Memorial Hospital, Rochester, was opened to the public on July 30, according to Dr. George W. Goler. The hospital is planned for the care of infectious diseases.

The Sisters of Mercy recently filed plans for the erection of a new \$300,000 hospital building at Buffalo. The six-story structure is tentatively planned to provide facilities for 150 patients.

North Carolina

Work has begun on the reconstruction of the wing of the North Carolina State Hospital for Insane, Raleigh, which was destroyed by fire several months ago. The new building will accommodate 100 additional patients.

“Clinical Photography”

Even in the time of Confucius a picture was worth “ten thousand words.” And now that the making of good pictures is so simple, quick and inexpensive their use is mandatory whenever it is a question of efficiently and accurately recording clinical data.

Our new book, “Clinical Photography” discusses in detail many of the applications of photography to the modern clinic. Ask us for your copy.

Eastman Kodak Company

Medical Division

Rochester, N. Y.



A MONEY SAVER!

Spotlessly clean floors are necessary in every hospital. Frequent scrubbing and mopping by old time methods cost an amount that is entirely out of proportion with the results obtained.

The FINNELL Electric Floor Machine will keep your floor maintenance cost at lowest possible point. It requires but half the time necessary for other methods. By saving time and labor the FINNELL will pay for itself within a year!

Most important of all to hospitals, the FINNELL will keep floors thoroughly clean and sanitary. It removes all the dirt and does not merely rub it around and cause the illusion of cleanliness.

The FINNELL is as necessary to the management of a modern progressive hospital as an up-to-date sterilizer or X-Ray machine.

A demonstration will show you the possibilities of this labor-saving invention and may be arranged without obligating you in any way.

Write for free booklet, "Your Questions Answered by Users."

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Floor Machine Headquarters for Twenty Years

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ELECTRIC FLOOR MACHINE

It Waxes - It Polishes - It Sands - It Scrubs

New Jersey

The construction of the initial unit of New Jersey's first private tuberculosis sanatorium which will be built near Califon in Hunterdon County has been assured by the purchase of property eight miles from the state sanatorium.

The Elizabeth City Hospital, Elizabeth, which has been operated as a Catholic hospital for the past two years, will soon return to its former non-sectarian management, according to an announcement recently made by Dr. John Saliba, owner. The three-year contract made with the sisterhood having expired, Dr. Saliba has made plans to operate the hospital with Dr. Mora S. Bulla as partner.

Finishing touches are being made on the new five-story structure of the new Homeopathic Hospital, East Orange, and the hospital will be available to patients in the early fall. One hundred beds will be provided for adults and twenty-five cribs for children.

Pennsylvania

Ground was recently broken for the construction of a \$250,000 addition to the Geisinger Memorial Hospital, Danville, which will add thirty beds to the present capacity of 150. An operating pavilion will be the main feature of the building.

The Ellwood City Hospital, Ellwood, recently announced the inception of a clinic for crippled children, which will be under the supervision of an orthopedic surgeon.

Rhode Island

At the opening of the campaign for \$100,000 for the extension of the Isabella Goff Nurses' Home of the Pawtucket Memorial Hospital, Pawtucket, Col. Lyman S. Goff donated \$50,000 towards the goal.

Tennessee

The two new dining room units for the Eastman Hospital for the Insane, Lyons View, were completed during July. The two additions of two stories each are connected with the main hospital building and the upper floors will be used for sleeping quarters for domestic help.

Construction of the \$400,000 addition to the Baptist Memorial Hospital, Memphis, will begin during early September, according to a recent announcement of the board of directors.

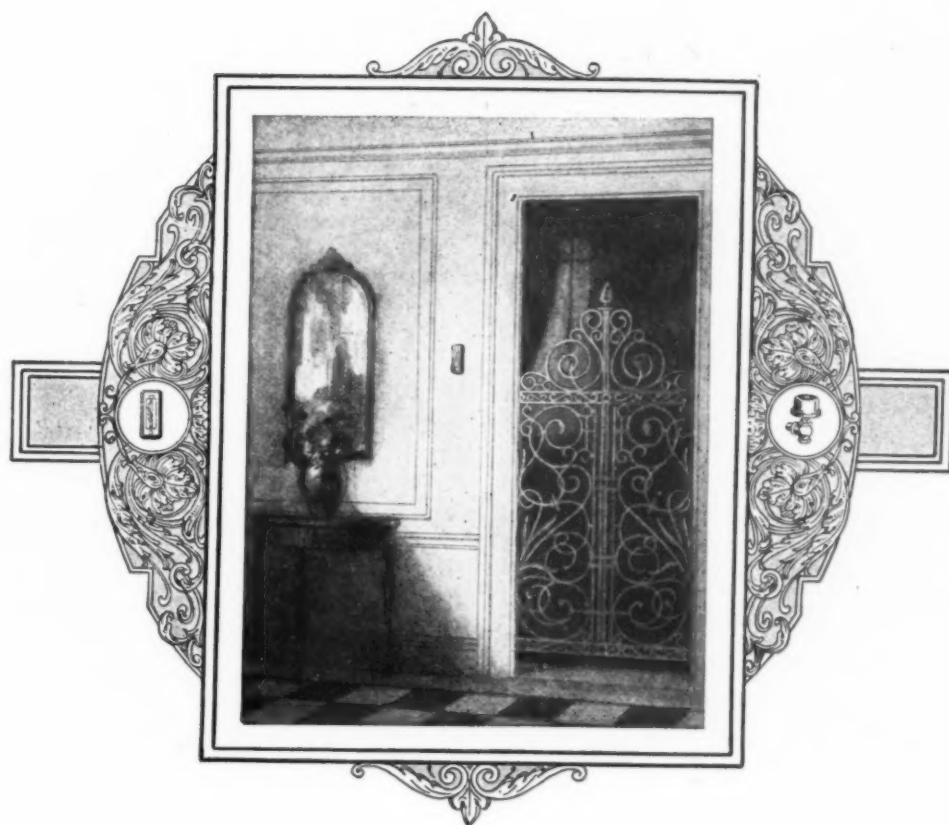
Texas

Construction work will soon begin on a new hospital building for Fort Worth, to be known as the W. I. Cook Memorial Hospital, according to Mrs. W. I. Cook, who has provided an endowment for the proposed institution.

Following the approval of a \$100,000 fund by the board of directors of Lubbock Sanitarium, Lubbock, construction work on the proposed addition will begin October 1. The new building will raise the capacity of the institution to 160 beds.

Canada

The property, buildings and equipment of the Sir Oliver Mowatt Memorial Sanatorium for Tuberculosis, Kingston, Ont., recently became part of the Rockwood Hospital for the Insane, Kingston. Patients of the former institution will be accommodated at the Hotel Dieu and Kingston General Hospital. The Rockwood Hospital for the Insane will be increased by 300 beds.



Hospital Heat By Hand Wrong

Turning on the heat of a corridor or room by hand results in an intense heat, an unhealthy condition, an unnecessary and excess fuel expense. Not any of those violations should be tolerated in a hospital. Johnson System Of Temperature And Humidity Control governs the heat without slightest variation from the degree stipulated: and governs the fuel consumption accordingly, saving from 15 to 35 per cent in fuel cost annually. The perfect success and satisfactory results of Johnson Control is attested to by the great many hospitals that have Johnson Control Service. And although your hospital is already erected installation can be readily made.

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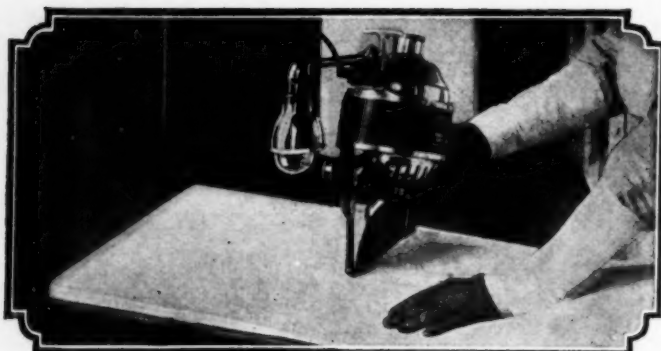
SYSTEM OF TEMPERATURE AND HUMIDITY CONTROL

The All Metal System: And Designed, Manufactured, Installed Solely and Entirely by Johnson Engineers and Mechanics: Assuring Thoroughly Correct, Reliable Results permanently.



Johnson Dual or Two Temperature Thermostat: one temperature for occupied rooms, another temperature for unoccupied rooms—day or night. Write for details.

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An Eastman reduces your store room costs

Because it cuts gauze, cellucotton, bandages and hospital garments quicker, and better than any other method, an Eastman Cutter deserves a place in your hospital.

Ask for free demonstration

Eastman Machine Company
BUFFALO, N. Y.

EASTMAN CUTTERS

Midwest Filters Clean the Air for All Operating Rooms in This New Hospital



The operating room floor of the recently completed University of Michigan Hospital is supplied with clean air, free of dust and bacteria, by Midwest Air Filters.

You can get clean air for your hospital at the very moderate daily operating cost of only 4c a day per thousand cubic feet of air supplied per minute.

Ask Dept. MH for complete details

MIDWEST AIR FILTERS

BRADFORD, PA.

Offices in Principal Cities

Trade News and Publications

Underwriter's Laboratories Report.—The 1925 report of the Underwriters' Laboratories, Chicago, on "Nu-Way" Domestic Oil Burners has been lately received. The report covers the type, description, use and construction details of the burner, while the investigation that has been made has brought valuable points on the design and construction, practicability, reliability of operation and durability of the burners. The report of the laboratories was such that the burner received the recommendation of the National Board of Fire Underwriters.

EsBee Water Coolers.—S. Blickman, Inc., Weehawken, N. J., have recently issued a broadside dealing with EsBee water coolers, manufactured by them. The coolers described and illustrated range from inexpensive types to those of higher listings and all are applicable for use in the modern hospital.

Hospital Equipment.—Bausch & Lomb Optical Co., Rochester, N. Y., have lately prepared "Hospital Equipment," a catalogue dealing with microscopes, microtomes, centrifuges, colorimeters, haemacytometers, projection apparatus and accessories. The several articles are well illustrated and specifications and descriptions are simply stated.

Cordleyware.—Cordley and Hayes, New York, manufacturers of Cordleyware, have recently distributed a new catalogue describing their products, which include waste baskets, pails, flower vases, keelers, funnels and water coolers, all made of long fiber pulp moulded, pressed, dried and indurated.

Grape Drinks and Desserts.—The Italian Vineyard Co., Los Angeles, Calif., purveyors of grape syrup, have recently issued a folder describing their vineyard, and offering numerous recipes using grape syrup, many of which are suitable for hospital use.

Mueller Brass Goods.—The Mueller Company, Decatur, Ill., manufacturers of plumbing, water and gas brass goods, have recently issued Catalogue G which lists faucets, drains, valves, traps, ferrules, shower and bath equipment, as well as all accessories. The 184-page catalogue is well prepared and has been somewhat simplified since the previous issue, the illustrations being confined to standard patterns and the items well arranged.

Baker Ice Machine Co.—The Baker Ice Machine Company, Omaha, Neb., has recently issued two catalogues, Baker System Refrigeration and Baker Uni-Flow Safety Head Compressor. The former is of value to the hospital in that methods of handling dairy products, vegetables, poultry and fruit in cold storage are explained. An approved chart of cold storage temperatures for eighty-six commodities is also included in this catalogue. The second catalogue deals with the construction of the compressor used in the Baker System of Refrigeration.

CONTROL HYPERACIDITY

—Without Discomfort

CONTROLLING hyperacidity—preventing acidosis—is now almost a part of the routine work of hospitals, dispensaries and clinics. These agencies exist for the protection of the health of the public and their service contemplates teaching the simple methods of safeguarding against disease.

It seems proper therefore, for the hospital personnel, recognizing that acidosis is the forerunner of much serious organic trouble, to appreciate the unique service of the original Milk of Magnesia (Phillips).

Frequently acidosis is first recognized when the patient enters the hospital or visits the clinic for diagnosis and treatment of some other ailment. There is usually a history of ill balanced metabolism and a tendency toward constipation. Whatever may be the underlying cause simple corrective treatment here discussed should be considered.

Gastric hyperacidity, acidity of the mouth and other of the more obvious manifestations of acidosis are promptly counteracted by Phillips' Milk of Magnesia which has a pronounced affinity for acids, the harmless resultant compounds being readily excreted.

The increasing use of sodium bicarbonate by the public to control "acid stomach" should be considered in this connection. Only a part of the bicarbonate is effective and that portion which produces carbon dioxide may be seriously detrimental.

Phillips' Milk of Magnesia being free from carbonates does not distend the stomach nor cause flatulence of the lower intestinal tract. Its antacid action is pronounced. A given quantity of Phillips' Milk of Magnesia neutralizes almost three times as much acid as a saturated solution of sodium bicarbonate and nearly fifty times as much as lime water. Further it has the additional merit of being laxative, a quality of importance here since constipation is so frequently the underlying cause of hyperacidity.

DOSAGE

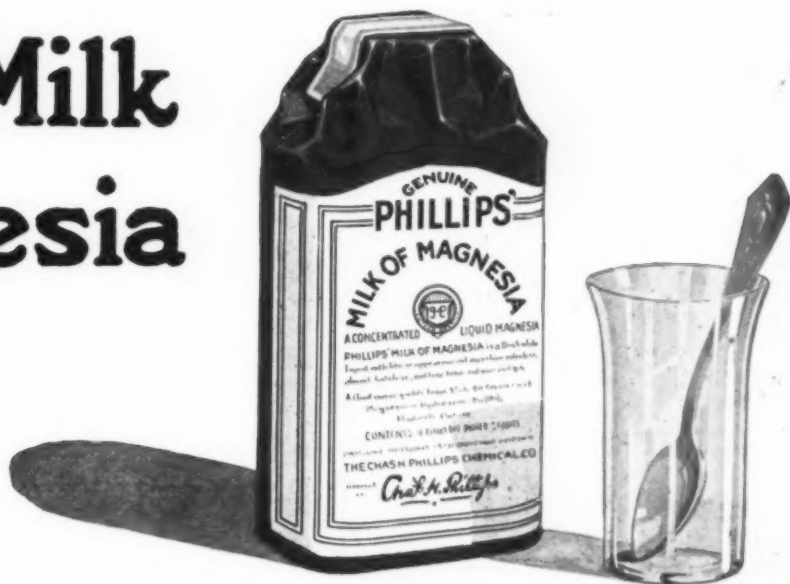
The usual dose of Phillips' Milk of Magnesia, as an antacid, ranges from one teaspoonful (4 c. c.) to one tablespoonful (16 c. c.). This amount should be mixed with an equal portion of cold water or milk and given half an hour after meals.

For its laxative effect, the adult dose is one to two fluid ounces (30 to 60 c. c.). The aperient action may be facilitated by giving the juice of lemon, lime or orange, half an hour thereafter.

PHILLIPS' Milk of Magnesia

CAUTION

Beware of imitations of Phillips' Milk of Magnesia. Kindly prescribe in original 4-ounce (25c bottles) and 12-ounce (50c bottles) obtainable from druggists everywhere.



"Milk of Magnesia" has been the U. S. Registered Trade Mark of The Charles H. Phillips Chemical Co. and its predecessor Charles H. Phillips since 1875.

THE CHARLES H. PHILLIPS CHEMICAL CO., New York and London

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Oakite Service Men, cleaning specialists, are located at

Albany
Allentown, Pa.
Atlanta, Ga.
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Buffalo
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Charlotte, N. C.
Chicago
Cincinnati
Cleveland
Columbus, O.
Dallas
Davenport
Dayton
Denver
Des Moines
Detroit
Erie
Flint, Mich.
Grand Rapids
Harrisburg
Hartford
Indianapolis
Jacksonville, Fla.
Kansas City
Los Angeles
Louisville, Ky.
Milwaukee
Minneapolis
Montreal
Newark
New Haven
Newburgh, N. Y.
New York
Oakland, Cal.
Philadelphia
Pittsburgh
Portland, Me.
Portland, Ore.
Providence
Reading
Rochester
Rockford
Rock Island
San Francisco
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Toledo
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Utica
Vancouver, B. C.
Williamsport, Pa.
Worcester
Stocks of Oakite materials are carried in these cities.

Oakite leaves no germ collecting film

FLOORS, walls, windows and other surfaces, washed with Oakite, not only look clean,—they are clean!

Oakite contains no soap. And unlike soap and soap compounds, it leaves no minute soap film to collect dust or dirt. It cleanses and rinses thoroughly. It does its work more quickly and cheaply than other materials. In hospital kitchens where scrupulous cleanliness is essential, every cleaning job is done better the Oakite way.

Send for our booklet "OAKITE IN INSTITUTIONS." Or better, have one of our service men call and give an actual demonstration. Just drop us a card. There is no obligation.

OAKITE

Industrial Cleaning Materials and Methods
OAKITE IS MANUFACTURED BY OAKLEY CHEMICAL CO.
18A THAMES ST., NEW YORK, N.Y.

Sanitary Products Co.—The Sanitary Products Co., Omaha, Neb., manufacturers of soaps, disinfectants and janitors' supplies, have distributed a thirty-page catalogue which includes specifications and illustrations of their products.

Sanitary Requisites.—The U. S. Sanitary Specialties Corporation, Chicago, has issued a folder describing their products which include waste receptacles, soap dispensers, insecticides, disinfectants, washing and scrubbing compounds and air conditioners.

Surgical Binders and Leggings.—E. W. Marvin Company, Troy, N. Y., manufacturers of supplies for nurses and hospitals, has prepared a folder treating surgical leggings, pneumonia jackets, and straight T, scultetus and breast binders.

Crescent Dishwasher Data.—The Crescent Washing Machine Company, New Rochelle, N. Y., have recently issued a forty-page catalogue outlining the advantages of the installations of Crescent Dishwashers in hospitals, hotels, restaurants and schools. The seven types, ranging in capacity from 1,500 to 18,000 dishes per hour, are specifically described and illustrated, and numerous testimonials from users of all types accompany each size. Specifications as well as details and connections for each washer are treated and the closing pages of the catalogue are devoted to suggested table layouts for the seven sizes.

Iceless Refrigeration.—A folder, Iceless Refrigeration, prepared by the Champion Electro Icer Co., Chicago, describes types of electro icers ranging from two-tray to eight-tray capacity.

Comfort First.—A catalogue, Comfort First, describing spring units, manufactured by Nachman Spring-Filled Company, Chicago, has been received. The spring units made by this company are used by makers of mattresses and upholstered furniture. The units consist of small, flexible steel springs encased in a separate compartment of burlap cloth, eliminating the rubbing of adjacent springs or of the burlap walls.

Nu-Way Automatic Oil Burners.—The Nu-Way Corporation, manufacturers of Nu-Way Automatic Oil Burners, Rock Island, Ill., have issued a booklet stressing features of their products, and including letters from satisfied users and two pages devoted to questions and answers on salient facts of oil burning.

Swim in Drinking Water.—Wallace & Tiernan Co., Inc., Newark, N. J., have recently issued a catalogue dealing with their system of chlorination of water for swimming pools. The catalogue includes several recent installations on the Pacific Coast as well as a typical plan of a swimming pool with recirculating system. The closing pages are devoted to a listing of users, which includes many nurses' homes.

Science in the Hospital Laundry.—The Cowles Detergent Company, Cleveland, has distributed a four-page folder, "Science in the Hospital Laundry," dealing with Escolite, an alkali detergent compound. An enumeration of qualities, questions and answers pertaining to Escolite and practical information of value to the washman are included in the folder.

Refrigeration.—The American Carbonic Machinery Co., Wisconsin Rapids, Wis., has dealt with the subject of refrigeration in a new forty-four page catalogue recently issued. The safety carbonic system used in many public and private structures is described at length, a history of the development of refrigeration is offered and a pictorial and written description of mechanical parts is available.



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